SAFER TORBAY

Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Jane
in March 2021

Review Chair: Gary Goose MBE
Report Author: Christine Graham
February 2024

Preface

The Safer Torbay Partnership and the Review Panel wish at the outset to express their deepest sympathy to Jane's (pseudonym) family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner, with all agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by the Safer Torbay Partnership under the statutory guidance that supports Section 9(3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Section 1 begins with an **introduction to the circumstances** that led to the commission of this review, and the process and timescales of the review.

Section 2 **sets out the facts in this case,** including a chronology to assist the reader in understanding how events unfolded that led to Jane's death.

Section 3 considers, in detail, the **agency involvement** with Jane.

Section 4 explores **what is known about Jane,** including her vulnerabilities and the evidence of the trail of domestic abuse. The section concludes with exploring trauma-informed practice.

Section 5 discusses **suicide and domestic abuse**.

Section 6 lists the **lessons identified,** with the **recommendations** following in **Section 7.**

Section 8 brings together **the conclusions** of the Review Panel.

Appendix One are the **Terms of Reference** for the review.

Appendix Two sets out the **ongoing professional development** of the Chair and Report Author.

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box. Examples of good practice are highlighted in italics.

Contents

Section One – Introduction

1.1 Summary of Circumstances Leading to the Review

1.1.1 This report of a Domestic Homicide Review examines agency responses and support given to Jane, a resident of the Torbay Community Safety Partnership area, prior to the point of her death in March 2021. Jane was only 36 years old when she died.

1.1.2 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before her death, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.1.3 Jane was a young woman who had lived, for the majority of her life, in the Devon area, close to her family. She had struggled with mental ill-health since childhood. The symptoms of her condition, including episodes of significant self-harm, resulted in her spending her teenage years in the care of the local authority. This care included 'placements' in the local area but also nationally when premises and facilities were identified appropriate to her needs.

1.1.4 As she grew into adulthood, her struggles with mental ill-health continued; however, she developed an independent lifestyle, leading to her living on her own in a flat (owned by her father), local to both her parents who had separated during her childhood.

1.1.5 In more recent years, Jane had disclosed more about her early life trauma and had been able to develop intimate adult relationships. The most recent of those relationships was with a local man. The police were called on several occasions to domestic abuse incidents involving Jane and her partner, and the police had, in the months prior to her death, issued a Domestic Violence Protection Notice (DVPN) to the man in an effort to prevent escalation of abusive behaviour by him towards Jane. At the time of her death, Jane was living on her own in a property she owned.

1.1.6 It was in the morning of a weekday in the Spring of 2021, when Devon and Cornwall Police raised an incident that described an email received from Jane at 1.50 am in the morning. The email said: *'I've taken 30 amnisuperid, 40 diclofenac sodium, 5 diazepam, 30 naproxen and 60 propanalol. I have two cats. The key is on the doorstep'*.

1.1.7 Officers were deployed to Jane's address sometime later. When there was no response to their knocking, officers forced entry into the property, and Jane was found deceased on the bathroom floor. CPR was commenced, and the ambulance service was called. When they arrived, they pronounced Jane dead at 8.25 am.

1.1.8 When detectives attended the address, they found no evidence of forced entry, disarray caused by a struggle, or any injuries to Jane. There were many medication blister packs, both full and empty, located both in her bedroom and other parts of the property. These supported Jane's statement of having taken large amounts of tablets.

1.1.9 It is within the context of prior domestic abuse that this review is established. At the time of publication, an inquest into Jane's death has not been held.

1.2 Reasons for Conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, agencies had been aware of domestic abuse towards Jane from Richard, who until recently, had been living in the same property, although they were no longer in a relationship. Richard was known to be a perpetrator of domestic abuse with several previous partners. The criteria were therefore met.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses, including changes to policies and procedures, as appropriate.
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

1.3 Methodology and Timescales for the Review

1.3.1 On 21st April 2021, Torbay Community Safety Partnership was advised by Devon and Cornwall Police of Jane's death. On 25th May 2021, the Domestic Homicide Review Multi-Agency Core Group met. Having considered the circumstances of Jane's death, the Group agreed that the criteria had been met and that a Domestic Homicide Review would be held.

1.3.2 On 21st June 2021, the Home Office was notified of the decision to hold a review. The independent Chair and Report Author were appointed in July 2021.

1.3.3 The Community Safety Partnership wrote to Jane's family on 14th July 2021 to advise them that the review would be taking place.

1.3.4 Ahead of the first panel meeting, agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998, which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 2018 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime. A chronology was compiled.

1.3.5 The first panel meeting was held on 23rd September 2021 on Microsoft Teams. The meeting was attended by:

- Devon and Cornwall Police
- Devon Integrated Care Board
- Devon Partnership Trust
- Torbay and South Devon NHS Foundation Trust
- Torbay Council – representing Torbay Community Safety Partnership

1.3.6 Apologies were received from:

- Ambulance Service
- Jane's GP practice
- Probation Service
- Sanctuary Housing (specialist domestic abuse service)

1.3.7 The ethos of a DHR was discussed, and the draft Terms of Reference were reviewed. At this meeting, Individual Management Reviews (IMR) were commissioned from:

- Devon and Cornwall Police
- Devon Partnership Trust
- Jane's GP
- Torbay and South Devon NHS Foundation Trust

1.3.8 It was agreed that the IMRs would cover, in detail, the time from 1st January 2020 as there appeared to be more relevant activity from that date but that earlier interactions would be summarised where relevant.

1.3.9 The Review Panel met three times, and the review concluded in February 2024. The panel met in full on 23rd September 2021, 15th March 2022 and 15th December 2022.

1.3.10 The review was not completed within six months due to the pressure on agencies commissioned to produce an IMR. Time was also taken to engage with Jane's family and friends.

1.4 Confidentiality

1.4.1 The content and findings of this review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the anonymity of the deceased, her family, and friends, Jane was used as a pseudonym. This pseudonym was requested by her mother.

1.4.3 The man with whom Jane had been in a relationship for between 12 – 24 months, and had separated from just prior to her death, will be known by the pseudonym, Richard. This pseudonym was chosen by the Report Author.

1.5 Terms of Reference

1.5.1 The review sets out to:

- Consider the impact of COVID-19 lockdown on Jane's mental health
- Consider the impact of domestic abuse on Jane's mental health, whether any potential impact was recognised, and whether she was supported
- Consider the impact of Jane's mental health on her ability to seek help in relation to the domestic abuse that she had experienced.

1.5.2 As the review evolved and more information was revealed, it looked further in depth at the following areas:

- What was known about Jane's background
- The vulnerabilities she faced
- The evidence of any trail of domestic abuse in this case
- The impact of trauma, its recognition and the approach of local agencies
- Suicide and Domestic Abuse

1.5.3 The full Terms of Reference can be found in Appendix One.

1.6 Dissemination

1.6.1 The following individuals/organisations will receive copies of this report:

- Jane's family
- Agencies represented on the DHR panel
- Domestic Abuse Commissioner
- HM Coroner
- Police and Crime Commissioner for Devon and Cornwall

1.7 Contributors to the Review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs, and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by this Chair or Report Author, or other body with whom they sought to consult, was made aware of the aims of the Domestic Homicide Review, and was referenced to the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation, either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Devon and Cornwall Police – Panel member and IMR
- Devon Partnership Trust – Panel member and IMR
- One Devon Partnership[1] – Panel member and supported the GP in preparation of their IMR
- Probation Service – Panel member
- Sanctuary Housing (specialist domestic abuse service) – Panel member
- South Western Ambulance Service NHS Foundation Trust – Panel member
- Torbay and South Devon NHS Foundation Trust – Panel member and IMR
- Torbay Council – Panel member

1.8 Engagement with Family and Friends

1.8.1 On 7th August 2021, the Chair and Report Author wrote to Jane's father, including details of AAFDA.[2] He telephoned the Report Author and indicated his wish to be involved in the review. He said that Jane's mother (his ex-wife) wished to be involved with the review and provided her details.

1.8.2 On 20th August, the Chair and Report Author wrote to Jane's mother, again including details of AAFDA.

1.8.3 In October 2021, the Chair and Report Author met with Jane's father and mother, each in their own home. Jane's mother was accompanied by her husband. At these meetings, details about AAFDA were given again, and contact details for Jane's brother were provided.

1.8.4 The Chair and Report Author wrote to Jane's brother on 21st October. After a telephone call with the Report Author, it was agreed that the Chair and Report Author would visit him in November. He was given details of AAFDA.

[1] Formerly Clinical Commissioning Group and Integrated Care Partnership
[2] Advocacy After Fatal Domestic Abuse

1.8.5 An update was sent to Jane's mother and to her father at the beginning of December 2021 and January 2022. A further update was provided when a new advocate was allocated at the end of January.

1.8.6 In December, the Chair and Report Author were advised that Jane's mother was now being supported by an advocate from AAFDA; therefore, from this point, communication with her was through the advocate.

1.8.7 During this meeting, details of Jane's friends, who may wish to be involved, were shared (with their permission). They were written to, and, at the end of March 2022, the Report Author visited one of Jane's friends. The friend contacted a further friend, on behalf of the review, who indicated that they did not feel that they had anything to contribute.

1.8.8 Both Jane's mother and her father were invited to meet the panel, but they did not feel the need to do so.

1.8.9 A draft report was shared with both Jane's mother and father, separately: their feedback was incorporated into revised versions.

1.8.10 The panel considered whether it would be appropriate and proportionate to contact Richard. It was decided that, as there was no criminal action against him, it would not be proportionate to use his health or police records to trace him.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Independent Report Author	
Simon Hester	Head of Safeguarding	Ambulance Service
Philip Leonard[3]	Detective Sergeant, Criminal Case and Serious Case Review Team	Devon and Cornwall Police
Nicola Seager	Detective Superintendent for Violence Women and Girls	Devon and Cornwall Police
Alexandra Doughty	Director of Intelligence[4]	Devon and Cornwall Police
Robin Scoville	Locality Practice Lead, Adult Services Directorate	Devon Partnership Trust
Collette Eaton-Harris	Domestic Abuse and Sexual Violence Lead	Devon Integrated Care Board
Louise Arscott	Head of Devon and Torbay Probation	Probation Service
Di Pooley	Area Services Manager (South West)	Sanctuary Housing
Deborrah Kelly	Chief Nurse	Torbay and South Devon NHS Foundation Trust

[3] Retired during the review.
[4] Job title at the time the review was commissioned: was DCI for South Devon.

Jane Schofield	Clinical Nurse Manager, Devon Sexual Health	Torbay and South Devon NHS Foundation Trust
Simon Acton	Torbay Drug and Alcohol Service Manager	Torbay and South Devon NHS Foundation Trust
Louise Stevens	Safeguarding and MCA Lead	Torbay and South Devon NHS Foundation Trust
Victoria McGeough	CSP Manager	Torbay Council

1.9.2 The panel members and IMR authors were independent of direct involvement with Jane and were of the required seniority in their organisation.

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 Gary Goose served with Cambridgeshire Constabulary, rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary led the police response to the families of the Soham murder victims. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility, as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner, developing a performance framework.

1.10.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years, managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings, as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.10.3 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author, respectively. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number that involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries, such as those undertaken by the IOPC, NHS England, and Adult Care Reviews.

1.10.4 Neither Gary Goose nor Christine Graham is associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[5]

[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

1.10.5 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available in Appendix Two.

1.11 Parallel Reviews

1.11.1 HM Coroner opened an inquest into Jane's death. At a Pre-Inquest Hearing on 26th August 2022, having heard about the progress with the DHR, the coroner decided to hold a further Pre-Inquest Hearing in January 2023, when he hoped to have been able to review a confidential copy of the draft overview report to assist him. This was shared with him in confidence.

1.11.2 At the time of publication, the inquest had not been held.

1.11.3 Following the discovery of Jane's death, the police referred themselves to the Independent Office for Police Conduct (IOPC). The IOPC, along with Devon and Cornwall Police's Professional Standards Department, undertook an investigation into the process surrounding Jane's email to them in which she detailed her overdose. The outcome of this is summarised later within this report: commencing at 3.1.36.

1.11.4 There were no other parallel reviews.

1.12 Equality and Diversity

1.12.1 Throughout this review process, the panel has considered the issues of equality. In particular, the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.12.2 Women's Aid state: '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[6] Women are more likely than men to be killed by partners/ex-partners. ONS data[7] shows that for the period April 2008 to March 2019, 925 women were killed by a partner or ex-partner, compared with 152 men.

[6] (Women's Aid Domestic abuse is a gendered crime, n.d.)
[7] Homicide in England and Wales, year ending March 2019, Office for National Statistics, February 2021

1.12.3 The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2022,[8] examined data from 2009 – 2019 of those who died by suicide whilst under the care of mental health services. They found that most patients who died had a history of self-harm (64%), and 25% had a comorbid major physical illness. 9% of deaths in this time were of women with a history of domestic abuse. The majority (81%) had a history of self-harm, and previous drug misuse (47%) was common. Nearly one third (29%) had been diagnosed with a personality disorder.

1.12.4 **Multiple and complex needs**

1.12.5 Harris and Hodges carried out a study in Nottingham that examined the 'Response to Complexity'.[9] In their work, they explain that intersectionality is a term used to express the interdependent nature of women's multiple and intersecting experiences. They point out that the intersecting experiences of women's lives can create very different contexts in which they experience seeking help and support. They quote Thiara, who points out that a failure to understand the intersecting nature of women's experiences can limit women's access to helping services.[10]

1.12.6 It has been acknowledged for several years that the experience of domestic or sexual violence can lead to mental health problems and substance misuse. In turn, people struggling with mental health problems and substance misuse are more vulnerable to further violence.[11]

1.12.7 The range of vulnerabilities that Jane experienced is discussed in detail within section 4 of this report.

[8] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2009–2019, and real time surveillance data, 2022, University of Manchester

[9] Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

[10] Thiara, R, Hague, G, Mullender, A, 2012, Losing out on both counts: Disabled women and domestic violence, Disability and Society 26, 6, 757–771. cited in Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

[11] Complicated Matters: A toolkit addressing domestic and sexual violence, substance misuse and mental ill-health, AVA, 2013

Section Two – Chronology

2.1 Background information

2.1.1 Jane lived in Torbay and had lived in Devon since childhood. Her parents separated when she was 8 years old. At the age of 11, the local children's services became involved; subsequently, this led to her becoming a looked after child. The circumstances relating to her moving to the care of the local authority are known to the review panel and remain private. However, they have been considered in relation to any learning that has arisen, and this is reflected within Section 4 of this report, which addresses the issue of childhood trauma.

2.1.2 It was between the ages of 13 to 17 that she was looked after in local authority care and had support and treatment from mental health services. She had been known to mental health services since 1997 and was first admitted to hospital at the age of 12. She was admitted to hospital frequently under both civil sections and Section 37 of the Mental Health Act. Jane's dysregulated behaviour as a child in care was of such a level that, at times, she was the sole resident of a premises – with multiple members of staff required to look after her and keep her safe.

2.1.3 Jane's mother has recalled that:

- Jane reported a rape by a 17-year-old (who her mother believed was 19) when she was around 12/13. She would not expand any further at the time, but as she became older, it is something that she wanted to pursue.
- She had never wanted Jane to go into care but wanted support to help to manage her behaviours. She has explained that she had sought help from CAMHS and Parentline, and that they moved to a bigger property so Jane could have a larger room in the hope that more space might help, but unfortunately this was not the case.
- For some time, Jane's mother home schooled Jane because she was excluded; however, this only lasted for two weeks before she went into respite care and then went into full time care for her protection.
- Jane's placements were often away from the local area, which led to her feeling isolated and making it difficult for family to visit.
- Jane's mother recalls that when Jane was 14 years old – in a placement where she had 2:1 care – she took some tablets and then ran into the road, where she was hit by a car (and sustained a damaged ankle). Jane's mother believes that this was an attempt to take her life. Jane's mother feels that this is relevant because it shows the early attempts that Jane made to take her life and some of the additional trauma that she faced (e.g., a damaged ankle after being hit by the car).
- Jane did well in her GCSEs, despite the turmoil of those years – she achieved a B in Law, a B in Sociology, a C in IT, and a C in Science (Single Award).

- Jane's mother has told the review that by 2001, whilst she was in placements, Jane was glue sniffing dependent, and she believes that this is relevant because of the impacts that long-term glue sniffing can have on the brain[12].
- At the age of 17, although Jane was still in a care setting and she had missed two years of schooling, she attended a local grammar school to complete her AS Levels (A in Religious Studies, A in Psychology and A in Sociology). She further completed one A Level (A in Sociology), achieving enough to be able to go to university if this was her wish.

2.1.4 Jane had a diagnosis of emotionally unstable personality disorder (EUPD).[13] Jane had a long history of deliberate self-harm (DSH). She was also diagnosed with fibromyalgia.[14] When she was particularly ill, Jane was described as someone who had a history of serious attempts on her life (most recent December 2014) and serious episodes of self-harm. It was identified that she could present with fixed beliefs regarding being evil and also that she would not get better. She had spent her adult life within the mental health system and found it hard to believe that she could exist outside of this system. She lacked a weekly structure and purpose to her life. She had a chronic level of suicidal ideation and, at times, an active investigation of ways to kill herself. She also suffered chronic low mood and lack of motivation. Jane's mother also recalls her being diagnosed with schizoaffective disorder. The family want to make it clear that this was an additional chronic mental health condition that affected her for life and for which she was prescribed anti-psychotic medication.

2.1.5 During her early 20s, she spent time in and out of psychiatric hospitals and was engaged consistently with services. The symptoms of her condition included her assaulting other patients and staff, and she spoke of thoughts of harming others and herself. However, in 2008, it was also identified that Jane was at risk from others, as she had a history of vulnerability to sexual exploitation by others.

2.1.6 **The period around 2008 was particularly challenging for Jane, and two incidents of note are included within this chronology – merely to indicate how difficult the symptoms of her mental health condition were for her and others to manage.**

2.1.7 In one incident, she assaulted a pregnant staff member at a local authority shared living facility where she was living. Jane pushed the staff member and then ran out into traffic, which she started to threaten with a wooden stick. She then returned and set fire to the curtains in her bedroom. The police were called and helped staff put out the fire, and she was detained under Section 136. She was later assessed in custody and detained under Section 3. She was then admitted to a ward on a medium secure psychiatric unit in Hertfordshire. Jane stated that she thought the staff member was playing 'mind games' with her and was refusing to answer a phone that she heard ringing, which suggested that she was hearing voices.

2.1.8 In a second incident, she assaulted a staff nurse on a hospital ward, resulting in a fractured forearm. This was after the staff nurse had asked her to change into more appropriate

[12] https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Famericanaddictioncenters.org%2Finhalant-abuse%2Fside-effects&data=05%7C02%7C%7Cfed0f782846f4893e09908dd3eb83fab%7C84df9e7fe9f640afb435aaaaaaaaaaaa%7C1%7C0%7C638735683238069046%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=tXA6RPlY3tRCflWdVIuP7gTyAijpPSsK7I4ELSVwhaQ%3D&reserved=0

[13] https://www.mind.org.uk/information-support/types-of-mental-health-problems/borderline-personality-disorder-bpd/about-bpd/

[14] https://www.nhs.uk/conditions/fibromyalgia/

clothing, as she was wearing a very short night dress in a communal area. Jane later stated that she thought that the nurse was being rude to her and calling her filthy and a tramp. Following this assault, she had to be physically restrained and was nursed in seclusion until 3 October 2008. As a result of this assault, she was also made subject to Section 37 MHA by Luton Crown Court. Whilst at this placement, Jane's mother recalls her being very unhappy for a variety of reasons, including poor relationships and communication with staff.

2.1.9 Another indication of her vulnerability came in January 2013, when she befriended a woman in a park and lent her £1250; she subsequently found out that the woman was a heroin user. Jane, herself, had begun to become involved in illicit drug use and cited the use of ketamine and other 'legal highs'.

2.1.10 In February 2013, Jane was attending a local college where she was doing well and received 25 credits in a variety of subjects.

2.1.11 In 2013, Jane reported that a person, with whom she was in a relationship, had raped her. She had reported the rape to the police and spoke about it with mental health staff. However, she did not feel that she could cope with the pressure of following through on the report so withdrew her report. She said that the man had made threats to kill her, to burn down her flat, and had damaged neighbours' cars, leading to her being asked to leave by her landlord. No charges were brought.

2.1.12 Jane's mother recalls that Jane took an overdose in 2014 that was triggered by the breakdown in a relationship.

2.1.13 During an assessment in September 2015, Jane reported no alcohol misuse but reported previous cannabis use between the ages of 16 and 19. She reported that the use of legal high stimulants helped with her energy levels and that they numbed problems related to physical pain.

2.1.14 Also in 2015, Jane reported financial abuse by a friend to whom she had lent money. Furthermore, that she had been coerced into sending a sexually explicit video of herself to them, which they intended to use to defraud men of money. She reported the matter to the police, changed her mobile number, and erased the perpetrator's number. A safeguarding alert was raised. It was noted that most of the abuse had occurred due to Jane feeling sorry for other people with problems. She said that she felt vulnerable and isolated. Jane declined to engage further with the police, and no charges were brought.

2.1.15 In 2016, Jane reported to the police that she had been sexually assaulted by a 17-year-old male when she was 13 years old. She named the person responsible for this offence but was clear that she did not want this to be investigated. She said that the reason she had reported it was so that it did not happen to anyone else. The matter was recorded, and significant police effort was put into continuing engagement with Jane in order to investigate the offence. No charges were ultimately brought.

2.1.16 In December 2019, Jane's care was provided by the GP. This was following a discussion with the multidisciplinary team (MDT), as Jane was not engaging with treatment from the mental health services or any of their attempts to contact her. Her GP was to re-refer her if it was felt that she required treatment in the future.

2.2 **2020**

2.2.1 On 8th January, Jane saw her GP for a mental health review. Jane said that she had been struggling over the last year, that she felt that her medication was not working, and that her psychosis was returning. She had not been seen by the mental health team for two years. On 9th January, Jane's GP referred her to the Single Point of Contact (SPOC) at the mental health service's triage team because of her ongoing or recurrent psychosis. The SPOC provides telephone triage and consideration of referral to other services, out of hours.

2.2.2 On 10th January, the police were called by a local vicar to a report of Jane sending alarming emails to him. One of the emails said 'Davinci' and another that she would buy a church. Devon Partnership Trust (DPT) was contacted by the police via the SPOC. Information was shared with the police because Jane had been sending emails, and the police were concerned for her welfare because she was possibly feeling suicidal. The police advised that they would be doing a welfare check.

2.2.3 On police attendance at her home address, Jane was found safe and well with a man who was by now described as her partner, Richard. She was talking about the Russian poisoning and the war between South Korea and North Korea. She appeared to be confused and felt that she was implicated in those events. She said that she desperately wanted help but had been told it was a six-month wait, which was too long. Jane said that she had support from Richard and her GP.

2.2.4 Later in the day, Jane attended the ED at Torbay Hospital with unusual behaviour. Unfortunately, when Jane arrived at the ED, staff did not ring the mental health team to request the assessment; therefore, Jane was in the waiting room for six hours and was not seen by anyone. As soon as the delay was identified, the call was made.

2.2.5 Jane was then seen by two Senior Mental Health Practitioners (SMHPs),[15] within the mental health suite of ED, for a mental health and risk assessment. Her assessment identified that she was low risk to herself from others and for self-neglect; however, she was medium risk to others.

2.2.6 As Jane was currently presenting in an acute crisis and voicing beliefs of a delusional/psychotic nature, the plan was that Liaison would refer Jane to the Crisis Resolution Home Treatment (CRHT) team[16] for a medication review and continued monitoring of mental state. Liaison would update her GP, and Out of Hours (OOH) numbers were provided. She was then visited by the CRHT on 11th January, and risks were identified as low in all aspects. She said that she had good support from her father, partner, and best friend. She said that she saw her best friend regularly and that they would often meet in the pub. She was unhappy about having to wait for a Mental Health Assessment Team (MHAT)[17] referral; however, she accepted that this was the correct avenue, as she and her GP were requesting medication advice. Jane was advised that her GP could liaise with a DPT psychiatrist regarding changing medication to her preferred choice of amisulpride.

2.2.7 On 12th January, Jane contacted the police and stated that she should be in hospital for a long time because she thought it was about time that she admitted to sexually abusing people at the Catholic school that she went to when she was 6/7 years old. It was considered

[15] This is a registered clinician from a core professional group – nurse, social worker, or occupational therapist.
[16] A team that provides assessment to patients presenting in crisis and, when suitable, treatment as an alternative to hospital admission.
[17] A team that provides planned assessment of mental health and treatment need to people not presenting in crisis.

that it was unlikely that this was true but that it would be appropriate to follow this up in slow time. The Devon Street Triage Service (The Devon Partnership Trust)[18] was contacted by the police, and the police were advised that Jane was known to DPT and was open to them. They were advised that she had an appointment with the MHAT and had a partner at home who was deemed to be her carer. The police decided not to attend that day but would make an appointment to meet her, which they did. However, Jane called the police to cancel this appointment.

2.2.8 On 16th January, Jane spoke to her GP on the phone and said that she was still struggling, that she wanted a change in her medication, and that she would like to have some respite. She advised the GP that the crisis team had advised her to call them. Jane was then seen by a GP at 5.05 pm: her father was also present. Her GP agreed to try changing her to amisulpride and changing her from lorazepam to diazepam. The GP agreed to expedite the letter to Community Mental Health Team (CMHT). The referral for a mental health assessment was sent by the GP on 17th January.

2.2.9 On 16th January, Jane called SPOC (DPT) and said that she was in an abusive relationship and that her partner had threatened to rip her organs out. It was noted that she had made untruthful comments in the past. The police were planning to visit Jane at 12 pm on 16th January, and she said that she would like CRHT team to be there to support her. She feared that she would be kidnapped and have her organs removed. Reassurance was given to Jane, and she agreed to go and rest and get some sleep.

2.2.10 On 18th January, Jane's GP referred her to the SPOC as an urgent referral because she was experiencing ongoing and recurrent psychosis. The urgent nature of the referral was upheld, and she was to be signposted to Torbay CRHT as urgent.

2.2.11 On 20th January, the crisis team (DPT) attempted to contact Jane by phone. A message was left to say that she had been referred to the CMHT and to ask her to contact them. The message also said that her GP could liaise with mental health services about changing her medication.

2.2.12 Jane spoke to her GP on the phone on 20th January, when Jane said that she was feeling better and less anxious. It was agreed to see her face to face on the Friday.

2.2.13 On 23rd January, the police contacted the crisis team (DPT) to say that Jane had given them information about having sexually abused children when she was a child. They felt that the report was because of her poor mental health and that they were closing the case.

2.2.14 A Registered Mental Health Nurse (RMN) from CMHT tried to contact Jane on 24th January for a Torbay Central Red Rag Review. A message was left for Jane, asking her to make contact. On the same day, the Change Programme noted that Jane was refusing any psychological interventions and did not want to engage with therapy or with the CMHT. She was therefore discharged.

2.2.15 On 24th January, Jane rang her GP surgery to request an appointment for the afternoon. The GP tried to call Jane on two occasions, without success. The same day, the CMHT tried (unsuccessfully) to contact Jane by telephone, and a message was left for her to make contact.

[18] Mental health practitioners who work with the police to provide information and advice about mental health.

2.2.16 On 31st January, an RMN (DPT) made an unannounced visit to Jane's home, as she had not responded to phone calls. Jane was described as passive aggressive to begin with but then became a little more friendly. She did not want to invite them in because she said it was untidy. She was assured it was OK and that they just wanted to check that she was OK. Furthermore, they wanted to let her know that she had been referred to the CMHT. Jane said that the only reason she had engaged was because she wanted her medication changed. She said that she preferred to work with her GP because she found mental health services unhelpful. She asked for the practitioner to feed back that it should be made easier for patients to get a medication review. She thanked them for calling but said that she did not want a service from CMHT at present. She clearly knew what to do when in crisis. The practitioner planned to speak to her GP to ensure that they knew that they could make contact at any time.

2.2.17 On 10th February, Jane was seen at home and said that she did not want contact from the CMHT and wished to remain in the care of her GP. It was agreed that, if she changed her mind, she could see her GP and have a rapid re-referral to the CMHT. She was discharged from CMHT back to her GP.

2.2.18 On 14th February, Jane had a telephone consultation with her GP. She said that she was feeling much better on her current medication, and it was agreed to increase the amilsulpride further and reduce the olanzapine.

2.2.19 On 25th February, the police were called by Jane's partner, Richard, who reported that Jane had a knife. Upon arrival, both parties were separated and spoken to by officers independently of one another. Richard said that she was suffering from severe mental health, which was deteriorating. He said that he had returned from the pub and was faced with his partner threatening him with a knife. In self-defence, he pushed her away, as he feared for his safety, and called the police. The knife was not used against the victim in any way and was soon put down on the floor. Jane said that she felt like cutting her partner but could not really give a reason as to why she felt like this. She was continually talking to herself and stated that she suffered from depression and anxiety.

2.2.20 After this incident, Jane told her mother that Richard had been threatening to have her sectioned, and he was telling her that she was 'mad'. She said that she had therefore had to defend herself and had taken the knife to keep him away from her.

2.2.21 The police did not have powers – under Section 136 of the Mental Health Act – to detain Jane and take her to hospital, as she was in a private dwelling. As Jane was clearly in a mental health episode and asking for help, the police requested an ambulance to take her to hospital for assessment.[19] The ambulance was requested at 9.07 pm but had not arrived at 11.26 pm. Ambulance Control advised that they had no resources to send. Jane was spoken to, and she agreed to be taken to hospital by the officers. The incident log was monitored by the duty critical incident manager, and officers were instructed to remain with Jane at hospital until her care was taken over by a medical professional.

2.2.22 Jane was taken by the police to ED at Torbay Hospital (arriving on 26th February), where she was seen by Liaison Psychiatry.[20] When assessed, Jane was viewed as low risk to herself but

[19] This is in line with Force Policy and Guidance and agreement with the South West Ambulance Service.
[20] This is the hospital-based mental health team, providing assessment for patients attending general hospitals.

high risk to others. It was agreed that a Mental Health Act (MHA) assessment would be undertaken. A hospital admission may have been beneficial; however, there were no beds available at that time. The request was made at 2.55 am, but they were busy and unsure when they would arrive. The police stayed in the department and would consider a Section 136 if she left the department. It was noted that Jane had not been out of the house for eight months due to anxiety and fibromyalgia.

2.2.23 The referral was accepted by Torbay Emergency Duty Service, but there was no capacity to undertake the assessment. The use of s4 was considered; however, due to Jane's compliance, the level of urgency did not exist. The assessment was then delayed until day services were available with two doctors to undertake the assessment.

2.2.24 At 2 pm on 26th February, after an assessment in ED, Jane was detained under Section 2 of the Mental Health Act by Torbay AMHP Service. This detention was to allow for an assessment of Jane's mental health and consider any changes in her medication that may be needed. The police officers remained with Jane until 4.41 pm.

2.2.25 Jane was admitted to the Sandford Ward at Cygnet Hospital. This is an acute female mental health inpatient ward. Jane was discharged from Cygnet Psychiatric Hospital on 4th March, when the s2 was rescinded.

2.2.26 On 4th March, the police were called because friends of Jane were refusing to leave her property. They had broken the dining table, causing damage. All parties were believed to be under the influence of alcohol. Jane was spoken to by officers. She said that she was happy that the people had left her address and did not want any further action taken, as the damage was very minor.

2.2.27 On 5th March, Jane had a telephone consultation with her GP. On the same day, Jane contacted DPT's client line to say that she had diarrhoea and vomiting and therefore could not accept any home visits. It was planned to call her later in the day. When she was spoken to, Jane said that she still felt unwell; therefore, she was not seen in the 48-hours follow-up timescale. She was reassured that she would be seen when she had been free of symptoms for 36 hours but that she could contact the team if she had any concerns.

2.2.28 The crisis team visited Jane at home on 8th March. Jane explained the difficulties that she was experiencing from fibromyalgia and that she was stressed because she had not heard about her application for PIP, which she had made in December. It was agreed that the team would contact a colleague who may be able to support her with her benefits. Jane said that she would like support from the CMHT, and it was noted that she was under rapid-referral due to her recent hospital admission. It was suggested that a medical review would be helpful, as she felt that she was not being supported by her GP, and her mental health was being impacted by her poor physical health.

2.2.29 On 13th March, DPT rang Jane. She explained that she had been experiencing diarrhoea and vomiting since she returned home from hospital. She was happy to have phone calls until she could be seen and did not feel there was anything she needed to keep herself safe over the weekend.

2.2.30 DPT CMHT visited Jane on 16th March for the seven-day follow-up. Jane was open to being supported to go out to yoga or swimming. She said that she would also like to see a GP about sight problems that she was experiencing.

2.2.31 On 23rd March, the police were called by Richard. He reported that Jane was in possession of a knife and was threatening to stab him. When officers arrived at Jane's home address, her partner had left. Jane was not holding a knife, and she disclosed that her partner had assaulted her by kicking her to the side of her body and placing his hands around her throat, strangling her for 10 seconds. She also reported that he had taken her bank card to purchase alcohol, as he had been drinking all day. Jane said that she and her partner were no longer in a relationship together, and he was not living with her. Jane did not have any visible injuries and declined any police action. Officers took Jane to her father's address to ensure that she was safeguarded for the night. Two crimes were raised: (1) common assault (report by Richard against Jane); and (2) assault (by Richard on Jane). Both crimes were filed as No Further Action (NFA). No DASH[21] risk assessment was created for either Jane or her partner.

2.2.32 The RMN from DPT telephoned Jane on 26th March. Jane said that she had broken up from her partner after they had had a fight, and the police were called. She had then stayed with her father for three days. Her father was very supportive. She said that she was staying strong and was not going to let her partner back into her house. She said that he was verbally abusive, particularly when he had been drinking. She was taking her medications. It was explained that due to COVID-19, face-to-face visits were not possible, and she said that she was happy with weekly phone calls.

2.2.33 Jane's GP received a summary from the mental health unit on 2nd April – when they asked for her bloods to be taken in 4 to 6 weeks and then every six months. The GP noted that they would ask for the bloods to be done in two months' time due to the COVID-19 restrictions.

2.2.34 DPT commenced a care plan on 15th April, and Jane's risk assessment was medium. The assessment said that Jane was currently doing well and was mentally stable. Jane asked for a medical review with the consultant at Torbay Central CMHT. Her risk increased to high when she was mentally unwell. She would often disengage from services and would say that she did not trust mental health services, as she felt let down by healthcare professionals. The risk to herself and from others was low, but the risk to others was high because of her previous history.

2.2.35 The RMN was unable to contact Jane on the phone on 15th, 16th, 17th, and 20th April.

2.2.36 On 20th April, Jane was seen in the GP surgery, when her bloods were taken.

2.2.37 On 23rd April, the RMN requested a psychiatrist review of Jane's blood tests to check her levels.

2.2.38 On 5th May, Jane spoke to the GP at 8.40 am, as she was not well. It was felt that it was unlikely to be COVID-19, but in view of her temperature, she was to be seen at the surgery. She was seen at 1.59 pm, and it was thought that she had gastritis. Consequently, she was given medication.

2.2.39 On 11th May, the RMN spoke to Jane. She confirmed that she was now back at home, and she sounded happy on the phone. She said that she had gastritis and was on medication. She had been tested for COVID-19 but was negative. Jane was due to have a medical review soon and was to continue with telephone support.

[21] Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment

2.2.40 On 13th May, the psychiatrist tried, unsuccessfully, to contact Jane by phone. A message was left for her to return the call. Subsequent attempts to contact Jane were also unsuccessful. Consideration was given to a referral to MARAC, but she was ultimately referred to the crisis team.

2.2.41 On 15th May, Jane emailed a police officer directly. The officer replied to ask if Jane needed any help, and she replied 'no'. There was no mention of suicide in this email.

2.2.42 On 22nd May, Jane spoke to her GP on the phone. She was concerned that she was not eating due to anxiety and was therefore losing weight. She requested a prescription for supplements. After reviewing her weight and body mass index, the GP informed her that she was not eligible for supplements. The GP advised that she tried to eat little and often.

2.2.43 On 24th May, Richard turned up at her home (in drink). Jane let him into property, and a verbal argument started; therefore, she asked him to leave. He left prior to police attendance. Jane did not disclose any offences and declined to answer the DASH, stating that she was no longer in a relationship with him. Jane was given advice to keep the doors and windows locked and to phone the police if she needed help. Jane declined to complete a DASH, but the officer attached a Refused DASH to the call. ***This is an example of good practice.***

2.2.44 Jane called the police on 3rd June to say that Richard was outside her home address (drunk) and was constantly ringing her doorbell. When officers attended, he had left. Jane was under the influence of alcohol. The officers described that Jane did not provide much information; however, she did say that six weeks earlier, Richard had held a knife to her and would not let her leave her address. More recently, he had forced her to kiss him a few times against her will. Jane did not want to make a statement concerning being held against her will or being kissed by him, but she did say that she would make a statement about the ongoing harassment of him knocking on her front door. It was agreed that the statement would be taken the following day. A crime report for false imprisonment and sexual assault was subsequently created. Jane was taken by the officers to her father's address for immediate safeguarding. On 5th June, Jane contacted the police by email. She advised that she had not been seen by an officer and no statement had been taken. This message was attached to the crime and brought to the attention of the SODAIT supervisor for allocation. A DASH was completed and graded as high. This was later downgraded to medium, following a review by Torbay Domestic Abuse Unit (DAU). This review was extremely thorough, and the rationale for downgrading to medium was well considered and correct.

2.2.45 On 9th June, the police received a call from Jane to say that Richard had turned up at her home address on the previous night (in the early hours) and had started banging on her door. He had also been constantly calling her mobile. Jane also wanted to know why no officer had taken a statement from her regarding the reports of harassment that she made on 3rd June. The incident log reviewed and cross referenced to the incident dated on 3rd June. The escalation from Richard was noted, and the risk was graded as medium/high. No officer was available to attend Jane's address that night to take details, so Jane was advised that an officer would call upon her on 10th June. Contact with Jane was unsuccessful over the next few days: this was due to demand issues and other calls for service. Furthermore, Jane had advised that she was not well with her mental health and requested any contact with her be delayed.

2.2.46 On 9th June, Jane's GP was requested by the mental health team to assess Jane, as they thought that she needed to be assessed urgently but did not have any appointments. The GP advised that this was not appropriate, and that if they felt she needed urgent assessment, they should provide this; however, the GP was happy to support a plan made by the specialist consultant.

2.2.47 The crisis team visited Jane at home on 10th June. Jane said that she was being supported by her father and had not been out except when accompanied by him. She was asked what support she would find helpful, and she agreed to a home visit on 12th June. This visit took place as planned. Jane had just woken up and said that she had been sleeping during the day due to fibromyalgia. She did not feel able to have a productive conversation until she had dressed and organised herself. She asked for them to come back later in the day. It was agreed that they would return at 3 pm. There is no record that this happened.

2.2.48 On 13th June, Jane was spoken to by the police (in person), and she made no report and did not provide a statement. A DASH was completed and graded as medium. Richard was located on 14th June outside her address (drunk), and he was arrested. Whilst in custody, he was interviewed for the reports of sexual assault and false imprisonment. He denied both reports and said that he and Jane were not intimate because he felt that he was more of a carer for Jane rather than a partner. He was released, and the crimes were filed 'Not Proceeded With'. Prior to being released, Richard was served with a Domestic Violence Protection Notice (DVPN), which he was happy to accept. The DVPN had the following conditions:

- Using or threatening violence against Jane and must not encourage or instruct or in any way suggest that any other person should do so.
- Intimidating, harassing, or pestering Jane and must not encourage or in any way suggest that any other person should do so.
- Having any direct or indirect contact, meeting, or any communication in person or via any other person, including text message, calls, social media with Jane or encourage any other person to do so on his behalf.
- The defendant is further prohibited from entering [Jane's road].

2.2.49 On 14th June, the crisis team visited Jane at home, as planned. After a conversation, Jane indicated that she was happy for her care to be returned to the CMHT.

2.2.50 Jane was advised of the DVPN on 14th June, and she was noted as being happy with this outcome.

2.2.51 On 15th June, Jane did not attend her psychiatrist review.

2.2.52 On 16th June, the police attended Torquay Magistrates Court and made the application for a Domestic Violence Protection Order (DVPO). Richard did not attend. The DVPO was granted with the following conditions:

- Using or threatening violence against Jane and must not encourage or instruct or in any way suggest that any other person should do so.
- Intimidating, harassing, or pestering Jane and must not encourage or in any way suggest that any other person should do so.

- Having any direct or indirect contact, meeting, or any communication in person or via any other person, including text message, calls, social media with Jane or encourage any other person to do so on his behalf.
- The defendant is further prohibited from entering [Jane's road].

The DVPO ran for 28 days and expired on 14th July. The details of the DVPO were loaded onto his screen on the Police National Computer (PNC).

2.2.53 On 18th June, Jane was discussed at Torbay Central CMHT multidisciplinary team (MDT), as she had now missed three appointments. Jane had indicated that she would like to wait until after lockdown for a face-to-face appointment. She was to continue having weekly telephone contact. On 19th June, Jane had a memory assessment.

2.2.54 Richard called the police on 19th June to report that his friend was receiving text messages from Jane, saying: 'I'm going to come and kill [Richard]. I know exactly where he is'. Jane was also reported to have threatened to shoot Richard if he came near Torquay, as she had a sawn-off shotgun. Research showed that Jane had no links to firearms; therefore, the threat was considered low.

2.2.55 On 21st June, the police received a report that Richard had breached his DVPO by calling Jane on her landline at 1.30 am. Jane declined to provide a statement but did sign a pocket notebook, giving details of the breach. Furthermore, she provided a screen shot of the call from her phone. A DASH was completed and assessed as medium. Richard would not make himself available to provide a statement or further information about the reported offence by Jane, and over the following days, he refused to answer his phone. This was primarily because he was evading arrest for breaching his DVPO on 21st June.

2.2.56 On 24th June, Jane contacted the Access and First Response out of hours triage service. She said that she needed to be re-referred urgently. The team tried to contact her, unsuccessfully, on 29th June and 10th July. On 13th July, a support worker left a message to say that they would visit her, but she did not answer the door or telephone. Jane's father would like to say that despite Jane's clear vulnerabilities at this point, no one tried to contact him to broker that contact with Jane. He feels that this would have made a difference, both in terms of direct support for Jane but also as a means of support for her by her father.

2.2.57 Richard was arrested on 9th July and taken to Torquay Police Station. He was placed before the local magistrates' court for breach of his DVPO on 10th July. He received a formal warning from the court but no substantive penalty. The reason for the delay in locating him was because he had no home address and knowing that he was wanted for breaching the DVPO, he went to ground.

2.2.58 On 12th July, the police received a call from Jane. She reported that Richard had contacted her (via her landline) 20 times during that day, saying how much he loved her. Jane believed that the DVPO had expired. Police records showed that the DVPO expired on 14th July, meaning that he had committed a breach and was arrestable for this.

2.2.59 Jane was not seen by officers until 16th July: two days after the DVPO expired. Between the 12th and 16th, several contacts were made with Jane, and she stated that she was unable to see the officers at that time. The incident log was also kept un-resourced, with several supervisory officers quoted as not being able to resource this incident due to more urgent demand and not enough officers to cover all outstanding incidents. When officers did

manage to speak to Jane on 16th July, she declined to provide a statement. She wanted Richard to be told by the police that she wanted no further contact with him.

2.2.60 On 17th July, the Registered Mental Health Nurse (RMN) spoke to Jane on the phone after receiving an email from her GP to say that they had received an email from Jane in which she asked for her medication to be increased. The GP was not happy to do this without approval of mental health services.

2.2.61 Jane spoke to her GP on 27th and 30th July. On 30th July, following the telephone consultation with her, Jane's GP referred her to the drug and alcohol service. The GP reported: 'Highly addicted to substances over counter, smokes 50 cigarettes daily. Needs addiction counselling. Spends £90 a week on her addiction. GP unable to help her.' Invitations for Jane to attend an assessment, were via letters, phone calls, voicemails, and texts. As Jane did not respond to any communication, the referral was closed.

2.2.62 On 1st August, Jane contacted the Access and First Response out of hours triage service. Jane had reported suicidal thoughts of drinking bleach. After conversations with Jane, it was decided that no action was needed.

2.2.63 The RMN tried, unsuccessfully, to phone Jane on 4th August. A text was sent to see if she was OK, but her phone was switched off. An email was sent to her psychiatrist about her psychotropics. It was noted that Jane may need a referral to the Pain Clinic for her fibromyalgia. She was on monthly telephone or video calls from the mental health service.

2.2.64 From the beginning of August, Jane was in regular contact with her GP about the symptoms of fibromyalgia that she was experiencing. She requested tramadol, which her GP declined due to the danger of dependence. The GP explained the links between fibromyalgia and mental health and advised Jane to focus on her overall well-being.

2.2.65 Between 1st September and 3rd November, there was text communication between Jane and the RMN. Jane indicated that she would like a referral to social care.

2.2.66 On 2nd September, the police received a call from Richard. He stated that Jane had assaulted him by punching him to the back of the head and throwing several plates at him, causing pain to the left shin and the head. He also told officers that Jane had smashed his mobile phone a few days previously. Jane was arrested on suspicion of common assault and criminal damage and taken to Torquay Police Station. During her formal interview with an appropriate adult, Jane admitted to throwing plates at Richard in frustration, as he would not leave her address when she asked him to. Jane presented as being more of the victim. Because of this and the fact that he had not provided a statement, she was released. The crime was filed as No Further Action. Jane was signposted to Torbay Domestic Abuse Service for support.

2.2.67 On 12th September at 3.27 pm, Jane called the police to report that at 3 am that morning, Richard had been knocking on her door. He then sent her a text, requesting money for drugs that he said he left for her at the address, but she refused to give him any money. He then sent a threatening text message, saying: 'I will cut your throat'.

2.2.68 Jane was contacted to arrange a suitable time for officers to speak to her. On each occasion, Jane had stated that it was not convenient, or officers had been dealing with other incidents. On day three, the incident log was 'Risk Reviewed' by a supervisor from the Police Control

Room, and shortly after that, an officer attended to speak to Jane. Jane informed the attending officer that she and Richard had now talked and were amicable again. Jane did not believe the threat to be credible, and she was not supportive of any police action. Jane stated that she was no longer in a relationship with him, and he was not welcome at her home. She said that he did not have a key to her home, and she would not be letting him in. A DASH was completed and attached, with the risk graded as low.

2.2.69 On 17th October, the police received a call from Jane to report that Richard had turned up at her home address and had refused to leave. Upon police arrival, he continued to refuse to leave and said that he would keep coming back all night; therefore, he was arrested to Prevent a Breach of the Peace. He was released the following day, once he was sober. Jane declined to complete a DASH, but one was completed by officers and risk graded as low.

2.2.70 On 25th October, an intelligence item was submitted after Jane had several thousand pounds worth of fake bank notes at her home address – located behind the sofa in the front room. Jane told the police that this money belonged to Richard; however, he made a counter report, saying that the money belonged to Jane.

2.2.71 On 10th November, a student RMN rang Jane to see how she was doing. She was not sleeping well. Her PIP was resolved, and she felt 'content and secure', as it paid for a cleaner and for her to use taxis. She said that Richard was now her best friend, that he was supporting her, and she said that: 'he is doing really well he was an alcoholic but he's not drinking anymore'. She was also seeing her father once a week. Jane's cats were a protective factor. She described them as 'almost her carers', as they provide her with love and affection. Jane said that her mood was not flat, and she did not feel overmedicated. Jane said: 'I'm not seeking life. I'm not functioning. I'm not washing enough, not cleaning'. These are all things Jane wanted to be doing. She said that the fibromyalgia was being managed better since she had treatment and was 'back to how it was before'. The RMN planned to speak to her psychiatrist to arrange a review of her medication – with a view to possibly increasing.

2.2.72 The student RMN called Jane again the next day, 11th, to talk about the plan to increase her medication. She was told that the psychiatrist had tried to contact her in the past, but she had not attended appointments. She said that it had been difficult in lockdown. The RMN said that the psychiatrist could make a recommendation to her GP, who could then increase her medication, and Jane indicated that she would prefer this.

2.2.73 On 12th November, Jane called the police to report delusional events that she believed had occurred in 2004. Because Jane was presenting as paranoid and experiencing persecutory delusions, which could increase the risk to herself and others, an ambulance was called to assess her.[22] There was no further police action.

2.2.74 DPT tried, unsuccessfully, to contact Jane by phone on 17th, 19th, and 20th November. On 20th November, an unplanned home visit was made by the RMN, and Jane answered the door on the first ring and invited them in. Jane said that she still saw Richard, as they were good friends, and saw her father every Wednesday afternoon for dinner and was planning to spend Christmas with her father's family. Follow-up attempts to Jane were unsuccessful, and the situation was discussed with her GP, who also had not had contact recently. The GP was asked to increase her dose of venlafaxine. This was actioned by the GP immediately, and a text was sent to Jane.

[22] The ambulance service has no record of attending.

2.2.75 On 23rd November, Jane called the police. She was upset that an ambulance had been called to her home address on 12th November and that the police had told mental health services about her previous report of being kidnapped. Jane felt that she had been put in danger because of this sharing of information. Officers attempted to contact Jane, but her mobile phone would only go straight to voicemail. An appointment was made to discuss her complaint.

2.2.76 On 30th November, Jane's GP called Jane on two occasions, but without success. On 3rd December, the RMN made an unplanned visit to Jane at home; however, the house was in darkness, and there was no reply.

2.2.77 On 7th December, after being unable to speak to her on the phone, the GP sent a text to Jane to advise that her prescription was ready for collection and that a GP would be in touch to discuss the information reported by email. The GP spoke to Jane on 8th December, and she was asked to attend the surgery, which she did later in the day. She was then sent a text with details of pelvic floor exercises and healthy living advice. On 9th December, Jane was advised (by text) that, following a recent blood test, she could cease the folic acid.

2.2.78 On 17th December, a school contacted the police because they had received 50 emails from Jane. Jane was saying that she was an ex-student of the school. The content of the emails had religious themes and references to 'the end' and 'I'm still here'. Officers attended Jane's home address, where she was found in the company of Richard. Jane was given words of advice about the emails. Jane advised the officers that she would contact her support worker.

2.2.79 On 18th December, the SPOC at Torbay and South Devon Foundation Trust received a safeguarding concern from the school, requesting a welfare check on Jane. This was actioned on 11th January 2021.

2.2.80 On 24th December, Jane was discussed at Torbay Central MDT. It was decided to discharge her from the service, and the deadline for the letter to be sent out was 18th December. She was discharged on 29th December, following non-engagement.

2.3 **2021**

2.3.1 Jane called the police on 7th January. She was repeating her delusional claims previously reported on 12th November 2020. No officer was deployed to Jane's home address, and she was dealt with over the phone by an officer from the Incident Resolution Centre (IRC). During that conversation, Jane told the officer that Richard was living with her, as a friend. She said that they were getting on well and that he had stopped drinking. She said that he was staying with her because of the COVID-19 restrictions but was out at work during the day. She described their relationship as non-intimate and that he slept on the sofa. She said that there was no domestic abuse taking place (with Richard) in her home. She agreed with the officer that she would contact her GP to discuss her anxiety. The incident log was closed.

2.3.2 On 11th January, the SPOC at Torbay and South Devon Foundation Trust made Devon Partnership Trust aware of the safeguarding referral they had received from the school on 18th December. The SPOC advised that Jane's father and GP were protective factors. The SPOC spoke to Jane's father, who said that he had daily contact with Jane by phone and that he felt that she was presenting well at the current time. The SPOC tried to call Jane, but the

call went to answerphone. On 11th January, the safeguarding referral was closed, with a recommendation that the mental health team complete a welfare call with Jane.

2.3.3 On 18th January, Jane sent a text to her GP surgery in which she said that she had been told that the manufacturers were temporarily ceasing production of venlafaxine and so she was seeking advice about her future prescriptions. This was passed to the in-house pharmacist, but there is no record of a response being sent.

2.3.4 On 11th February, Jane had a telephone consultation with her GP and advised that she had had a tremor for two years, although she had not mentioned it previously. She was given a prescription for beta blockers. On 15th February, Jane had her first COVID-19 vaccination.

2.3.5 On 22nd February, Jane's friend, who lived in Somerset, called the police. Jane had earlier spoken with her friend and said that Richard kept visiting her home address, bringing friends with him, and staying overnight before leaving again. The friend felt that Jane was being manipulated by him and that she was at high risk of suicide. Jane had also told her friend that she had been assaulted by one of Richard's friends and that Richard had punched her in the head. Officers attended Jane's home address the same day and spoke to her. Jane told the officers that she had been assaulted by an unknown male, but it was not Richard. Jane wanted Richard to stop coming to her address and sleeping there. Jane also stated that she and Richard were using cocaine when he could get hold of it. She suffered with fibromyalgia and was in daily pain and always tired. Jane was medicated for this and said that she was taking the medication as prescribed. Jane stated that she was physically very weak because of fibromyalgia and unable to defend herself. She suffered with anxiety and was too afraid to leave home; however, she recently went out for her COVID-19 vaccination. Whilst in attendance, the officers noted that the flat was messy and dirty. There were empty alcoholic receptacles in the lounge, which Jane stated belonged to Richard and not her. Jane had telephone support from her father; however, he was currently not physically helping because he was concerned over COVID-19. As Jane declined to make a statement, no further police action was taken.

2.3.6 On 8th March, Jane sent an email to her GP. In response, the GP sent a text message the same day and asked Jane to have a medication review and to make an appointment. On 9th March, Jane was sent a text message by the GP surgery, asking her to book a thyroid blood test. This was a routine test, as Jane had Hashimoto's disease: this meant that, due to her medication, her thyroid did not function. At this time, Jane's mother recalls that Jane was concerned that she may have symptoms of Parkinson's disease as a result of the mental health medication that she was prescribed.

2.3.7 On 10th March, the police received an email from Jane. It stated that she was worried about a comment made by Richard, who was currently staying with her. An officer attended the address and established that there were no criminal offences, but Jane wanted Richard to leave because of his abusive language when he was under the influence of alcohol. She said that his language was affecting her mental health, and she felt suicidal. She had told him to leave on several occasions, but he refused.

2.3.8 Later that day, the same officer re-attended the address and spoke to Richard. He was given suitable words of advice about his behaviour, and it was agreed that he would leave the address by the weekend. Jane was present, and she was happy with this arrangement.

2.3.9 After leaving the address, the officer received a concerning text message from Jane, saying that she had a suicide plan. The officer immediately rang Jane and spoke to her at length. Jane was described as emotional, and through talking to her, it was established that although Jane had a suicidal plan in her head, she did not have any immediate intentions. Jane was offered an ambulance by the officer, but she refused this. The officer then spoke to First Response and requested that they contact Jane that night and that contact could not wait for the following day. First Response agreed to contact Jane that day. The officer also spoke to Richard, who was staying with her. He said that there had not been a change in Jane's behaviour. He was advised that if Jane's behaviour changed, or there were concerns, to contact 999 for an ambulance. Jane accepted the offer of a welfare check by the officer on the following day.

2.3.10 On 10th March, Jane had contact with Access and First Response, via the police. She was spoken to at 10.15 pm, when she appeared willing to engage in a call with the worker. When she was told of the referrer's (PC) concerns about her thoughts to end her life, Jane said: 'it's not a life, it's an existence'. She would not answer direct questions about deliberate self-harm (DSH) or suicidal ideation. Her speech seemed pressured, and her responses were increasingly incongruent and tangential. She asked to be contacted the next day (the late morning). The worker called the referrer (PC) for additional information about their involvement. The police said that they were concerned for her well-being after her partner had said: 'he knew that the sewage pipes would be blocked soon', insinuating that she would be disposed of. The police had attended and advised him to leave the property by the weekend. The police said that they would check on her the next day, from 2 pm onwards, and to see if she wanted Richard to leave.

2.3.11 First Response contacted the officer later that day and informed them that they had spoken to Jane, although she was reluctant to talk to them. First Response said that they would make further contact with Jane the next day.

2.3.12 The First Response team called Jane on 11th March. It was noted that low mood was evident, with suicidal ideation; however, Jane said that she was seeing her GP later in the day. She informed them that she was using Mental Health Matters and knew who she could contact. The information was provided to her GP.

2.3.13 Later in the day, Jane had a telephone conversation with her GP in which she said that she was worried about Parkinson's disease due to her medication, and she suggested that she should be on a different medication (to that prescribed) for her tremor. She was offered an appointment for the same day, which she was not able to make. She had an appointment for 12th March but did not attend. On 15th March, the GP surgery received a request for prescriptions from Jane that were unusual, so she was asked to contact the surgery and to make an appointment.

2.3.14 The same police officers attended Jane's home address on 15th March and found Richard at the address. He had packed his belongings and was waiting for a friend to attend later that day with a van. Jane told the officers that she wanted him to leave immediately. He complied with Jane's request and left with some belongings and agreed with Jane that someone would collect the remainder of his belongings later that day. The officers remained with Jane to ensure that he did not return. They gave her advice about keeping the front door locked and not letting him in if he called back. Jane appeared happy with this advice and relieved that Richard had finally left. The officers wrote up a statement about their visit and submitted some intelligence to be attached to both Jane and Richard's local policing

records – so other officers would be able to access this information, should they have cause to attend the address.

2.3.15 On 18th March, Jane's GP was unable to contact Jane on her mobile or landline. The GP tried to call on two occasions. The GP practice received an email from Jane on 19th March.

2.3.16 On 20th March, the police received an email, sent from Jane at 1.50 am on 19th March, which stated that: 'I've taken 30 amnisuperide 40 diclofenac sodium 5 diazepam 30 naproxen 60 propanalol I have two cats the key is on the doorstep'. When the police attended, no response was received to them knocking, and the keys had been removed by a neighbour on 19th March for safekeeping. The police forced entry, and Jane was found deceased on the bathroom floor.

Section Three – Detailed Analysis of Agency Involvement

The chronology set out in Section 2, details about the information known to agencies involved. This section summarises the totality of the information known to agencies and analyses their involvement. It is recognised that there are elements of duplication of some of the information within this section and the previous section. This enables the interactions – between each agency and Jane – to be considered individually without constantly back referring to the previous chapter. More general considerations are analysed within Section 4 onwards.

3.1 DEVON AND CORNWALL POLICE

3.1.1 Jane was known to Devon and Cornwall Police, with records dating back to 1998. Whilst there are some references to Jane being the victim of crime and an offender on occasion, her records indicate that police involvement was primarily centred around Jane's attempts to self-harm and take her own life. There were two local police warning markers attached to Jane's records: one being for mental health, and one being for suicide. These appear to both originate from an incident on 19th March 2006, where she had attempted to jump from the top of a multi-storey car park in Torquay. Jane was subsequently detained under Section 136 Mental Health Act.

3.1.2 There are two references to Jane being the victim of domestic abuse in 2020, prior to her relationship with Richard. These date back to September 2012 and July 2018, both with different partners at the time.

3.1.3 In 2013, Jane reported that a person, with whom she was in a relationship, had raped her. She said that although she had reported the rape, she did not feel that she could cope with pressing charges. She said that this man had made threats to kill her, to burn down her flat, and had damaged neighbours' cars, leading to her being asked to leave by her landlord. Jane did not feel able to further engage with the police over this incident, and no charges were subsequently made. Various safeguarding processes were activated, however. Given that this incident was over eight years prior to Jane's death, this investigation has not been fully reviewed as part of this review.

3.1.4 Jane made a report to the police in 2016 that she had been sexually assaulted by a 17-year-old male when she was 13 years old. She named the person responsible for this offence but was clear that she did not want this to be investigated. She said that the reason she had reported it was so that it did not happen to anyone else.

3.1.5 The police have scrutinised their involvement in this latter incident and have provided a full report to this review. This review asked them to look at the decision-making at the time and consider lessons that could be learned.

3.1.5.1 Considerations at the time

3.1.5.2 The officer from the Force Demand Reduction and Compliance Team (DRCT), who took the initial details and recorded the crime, has shown consideration for the fact the Jane is vulnerable. On the page attached to the crime report for the victim's details, Jane has been designated a victim of a serious crime (sexual assault) and is entitled to an enhanced service. Enhanced service means that Jane is considered vulnerable and intimidated in respect of special measures should the investigation progress to court. This is standard practice for any

person who is a victim of a child sexual assault and not necessarily because of their own personal circumstances or individual vulnerabilities. There is mention on the victim page that Jane suffers with mental health issues, but this is not expanded upon.

3.1.5.3 The Victim Needs Assessment (VNA) and contact by the Victim Care Unit (VCU) are standard procedure for any victim of crime, and in line with Force Policy and Guidance.

3.1.5.4 Throughout the investigation notes, there is no mention of Jane's vulnerabilities. In 2016, Jane had warning markers on her personal data held on the local police computer system (UNIFI). These warning markers were for mental health and suicide. These were not acknowledged by any officer and were not considered when dealing with Jane. Neither was any consideration given to liaising with partner agencies – before, during, or after the investigation.

3.1.5.5 A Vulnerability Screening Tool (ViST) was not completed; therefore, the information about the report of sexual assault was never shared with the partner agencies who may have been engaged with Jane.

3.1.5.6 **Learning in relation to support for victims that take steps to disclose historical sexual offences, given what we now know**

3.1.5.7 The initial report and acknowledgment of Jane's vulnerabilities is evident in the crime report; however, there are lessons to be learnt about the engagement with Jane during the investigation stage.

3.1.5.8 Whilst there is information available in 2016 (at the time of the report) to highlight that Jane was vulnerable and suffered with mental health issues, what is more evident now is that those mental health issues increased over time and may have been exacerbated, in part, by the sexual abuse Jane suffered in 1998. There must be a degree of caution in this thinking because Jane had also made another report of more recent sexual abuse (dated 2013). In that incident, the matter was dealt with jointly between the police, a care worker, and Jane's social worker, with it being noted that there was a good exchange of information between the agencies and recognition of Jane's vulnerabilities.

3.1.5.9 This poses the question as to why the same level of service and support was not afforded Jane when she made the report of historic sexual abuse in 2016. It is the opinion of the IMR author that this is down to a lack of professional curiosity by the officer who was allocated the job of speaking to Jane face to face and taking initial details. Had there been more professional curiosity and a more holistic approach to Jane, as evidenced by the 2013 incident, the level of support would have been far greater, which would have included an opportunity to share the information about the report with partner agencies.

3.1.5.10 Devon and Cornwall Police, along with all UK police forces, deploy Sexual Offence Liaison Officers (SOLO) to certain sexual offences. The SOLO is a police officer specially trained to respond to acute and historic rapes and serious sexual offences. Serious sexual offences are generally held to include any other penetrative offence but can include non-penetrative offences if by the circumstances it is deemed serious. This is considered on a case-by-case basis. The SOLO is responsible for responding, co-ordinating forensic examinations, interviewing a victim of a rape or serious sexual assault, and co-ordinating support. The current model for the SOLO is in line with national standards of service response to reported incidents of sexual offending. Why then was a SOLO not deployed for Jane in 2016 when

she reported historic sexual assaults? Primarily, the reason would have been that the nature of the report (being forced to touch a man's genital area with her hand) would not ordinarily attract such a deployment. This is not to play down the effect the assaults had on Jane, either at the time or later in her life, but more a recognition that the circumstances would not fit the criteria for the deployment of a SOLO. However, upon reflection, there is a case to suggest that given Jane's vulnerabilities, a SOLO may have been a more appropriate person to speak to her and take details. There is, however, a finite number of SOLOs to deploy, and the Force has to triage and manage the demand for their skills. Furthermore, it is solely dependent on the seriousness of the assault and the potential for any forensic opportunities.

3.1.6 **23rd March 2020**

3.1.7 The police were called by Richard. He reported that Jane was in possession of a knife and was threatening to stab him. When officers arrived at Jane's home address, Richard had left. Jane was not holding a knife, and whilst talking to her, Jane disclosed that he had assaulted her by kicking her to the side of her body and placing his hands around her throat, strangling her for 10 seconds. She also reported that he had taken her bank card to purchase alcohol, as he had been drinking all day. Jane said that they were no longer in a relationship together, and he was not living with her. Jane did not have any visible injuries and declined any police action. Officers took Jane to her father's address to ensure that she was safeguarded for the night. Two crimes were raised: (1) common assault (report by Richard against Jane); and (2) assault (by the Richard on Jane). Both crimes were filed as No Further Action. No DASH was ever created for either Jane or Richard.

The review agrees with the IMR author that a DASH should have been completed for both Jane and Richard, particularly as Jane disclosed strangulation. Both made reports of domestic abuse, and Force Policy and Guidance directs that a DASH will be completed in these circumstances.

At the time of the incident, the attending officers had the opportunity to sit down and go through the risk assessment questions with Jane. Richard did not make himself available, but a DASH should still have been completed by the officers and marked as REFUSED.

The DASH would then have been attached to their police records and would have formed part of a holistic overview of the associated risk between the two of them.

The review notes that the crime reports were subject of several supervisory reviews; however, at no stage was the lack of a DASH identified.

Completion of a DASH would have allowed the risk to be assessed and recorded.

Jane's report of strangulation was not subject of a specific crime complaint of assault, despite the evidence of strangulation being a high-risk marker for homicide, but rather was linked to the theft of her bank cards.

Neither party was provided with details of domestic abuse support services.

An evidence-led prosecution appears to have not been considered by officers, despite the serious nature of the assault.

The review is advised that over recent months, considerable work has been done through the Strategic Safeguarding Improvement Hub and Criminal Justice Department to increase training and raise awareness for all investigative officers, and their supervisors, to be considering evidence-led prosecutions at an early stage of all investigations, most importantly those cases involving domestic abuse.

The Force's latest published HMIC Inspection (PEEL 2018-19),[23] rates the aspect of protecting vulnerable people as 'Good'. That review reinforces the work being done to improve services for the vulnerable and identifies some ongoing areas for improvement.

3.1.8 **3rd June 2020**

3.1.9 Jane called the police because Richard had been outside her address (drunk) and was constantly ringing her doorbell. When officers attended, Jane was under the influence of alcohol and was reluctant to provide information. However, she disclosed that, six weeks earlier, he had held a knife to her and would not allow her to leave the address and, on a more recent occasion, he had forced her to kiss him against her will. Jane did not feel able to make a statement about these incidents but would make a statement about the harassment of him knocking on her door.

3.1.10 The next day, Jane's statement was taken, and a crime was created for false imprisonment and sexual assault. On 5th June, Jane contacted the police to say that she had not been seen by an officer and no statement had been taken. This message was attached to the crime and brought to the attention of the SODAIT supervisor for allocation. A DASH was completed and graded as high. This was later downgraded to medium, following a review by Torbay Domestic Abuse Unit (DAU).

The IMR author commented that the review was extremely thorough, and the rationale for downgrading to medium was well considered and correct.

3.1.11 However, the Report Author asked for all of Jane's DASH risk assessments to be reviewed, with a view to identifying when she disclosed strangulation as part of the assessment. This was one of the two occasions.

The additional risk that previous strangulation poses is well researched. 68% of women who are at high risk of domestic abuse will experience near-fatal strangulation.[24] Non-fatal strangulation has been shown in some studies to increase the risk of homicide sevenfold.[25] The review believes that, considering the disclosure of strangulation, the downgrading to medium was not appropriate and should have remained as high, and a referral to MARAC should have been made.

[23] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-devon-and-cornwall.pdf

[24] Taliaferro, E., Hawley, D., McClane, G.E. & Strack, G, 2009, Strangulation in Intimate Partner Violence. *Intimate Partner Violence: A Health-Based Perspective.* Oxford University Press, Inc., 217-235. Cited in Strangulation in Intimate Partner Violence, V6.24.19, Training Institute of Strangulation Prevention

[25] Campbell et al., 2007, cited by Monckton Smith et al., Domestic Abuse, Homicide and Gender, Palgrave Macmillan, 2014

Recommendation 1

It is recommended that the Home Office instigates a review into DASH risk assessments to ensure that where strangulation is a factor, the risk is rated as high – regardless of the other answers given.

The review is concerned that officers are not aware of dangers of strangulation and the importance that it places on safeguarding the victim. The review has been advised that, since strangulation has been introduced as a specific offence, training has been provided to officers.

Specifically, the changes made are as follows:

Since the new non-fatal strangulation/choking offence[26] came into force on 7th June 2022, Devon and Cornwall Police have recorded 159 instances that also carried a domestic abuse flag. These were all recorded for the year ending November 2022. Strangulation/choking offences had consistent application of a domestic abuse flag, which shows that officers are aware of highlighting the offence within a domestic abuse situation.

Prior to the new legislation, reports of strangulation/choking would invariably have been recorded as a minor assault. The new offence of non-fatal strangulation/choking allows for the act to be recognised and recorded independently from other assaults.

In the time leading up to the introduction of the new offence, Devon and Cornwall Police produced guidance and advice for all officers, which included signs and symptoms of non-fatal strangulation/choking, how to investigate the offence, and other useful advice. This guidance was made available on the Force Intranet site and was subject of targeted messages to officers. The new legislation is also discussed during DA Matters Training, which is an ongoing training schedule to raise the number of DA Champions within the Force.

Members of the DHR panel confirmed that they had seen a change in the approach of the police to strangulation, and they are now seeing it as a high-risk indicator.

3.1.12 **9th June 2020**

3.1.13 The police received a call from Jane to say that Richard had turned up at her home address on the previous night (in the early hours) and had started banging on her door. He had also been constantly calling her mobile. Jane also wanted to know why no officer had taken a statement from her regarding the reports of harassment that she made on 3rd June. The incident log was reviewed and cross referenced to the incident dated 3rd June. It was noted that there was escalation from Richard, and the risk was graded as medium/high. No officer was available to attend Jane's address that night to take details, so Jane was advised that an officer would call upon her on 10th June. Contact with Jane was unsuccessful over the next few days: this was due to demand issues and other calls for service. Furthermore, Jane advised that she was not well with her mental health and requested any contact with her be delayed.

[26] https://www.cps.gov.uk/legal-guidance/non-fatal-strangulation-or-non-fatal-suffocation

The IMR author identified that, whilst there were many factors, there were opportunities to take a statement from Jane earlier in the investigation. By delaying, Jane may have felt that her report of harassment was not being taken seriously.

No information about domestic abuse services was shared with Jane.

3.1.14 **14th June 2020**

3.1.15 This incident is linked to the incident above, and Richard was located on 14th June outside Jane's address (drunk): he was subsequently arrested. Whilst in custody, he was interviewed for the reports of sexual assault and false imprisonment. He denied both reports and said that he and Jane were not intimate because he felt that he was more of a carer for Jane rather than a partner. He was released, and the crimes were filed 'Not Proceeded With'. Prior to being released, he was served with a DVPN, which he accepted. The DVPN had the following conditions:

- Using or threatening violence against Jane and must not encourage or instruct or in any way suggest that any other person should do so.
- Intimidating, harassing, or pestering Jane and must not encourage or in any way suggest that any other person should do so.
- Having any direct or indirect contact, meeting, or any communication in person or via any other person, including text message, calls, social media with Jane, or encourage any other person to do so on his behalf.
- The defendant is further prohibited from entering [Jane's road].

The review notes that, before the decision to take no further action was taken, the evidence was reviewed by a Detective Sergeant in the Sexual Offences and Domestic Abuse Investigation Team (SODAIT), who was qualified to review evidence. This review noted that Jane was not able to provide a statement, there were no independent witnesses, there was no corroborative evidence, and that Richard denied the reports.

The review agrees that, under the circumstances, it was not possible to consider an evidence-led prosecution.

The review notes that the DVPN was issued, and *this is an example of good practice.*

Although the DVPN was issued, there is no evidence that Jane was provided with details of organisations that could support her.

The review is assured that now, when authorising a DVPN, the Superintendent will be looking to ensure that there are appropriate plans in place to support the victim during this time.

3.1.16 **12th July 2020**

3.1.17 The police received a call from Jane. She reported that Richard had contacted her (via her landline) 20 times during that day, saying how much he loved her. Jane believed the DVPO

had expired, but police records showed that the DVPO expired on 14th July, meaning that he had committed a breach and was arrestable for this.

> As officers did not ensure that evidence was secured from Jane at an early stage, and then locate and arrest Richard, the incident went un-resourced for four days, despite all outstanding domestic abuse incidents being discussed by police supervisors every morning at the Daily Management Meeting (DMM). The purpose of this meeting is to ensure that any incidents carrying risk are resourced and managed locally. This was not the case for this incident; therefore, four days elapsed before Jane was spoken to. In that time, the DVPO expired.
>
> There is no record of this breach being discussed in the minutes for this DMM, despite there being a specific title in the minutes for DVPN/DVPO where this should have been discussed.
>
> There is no record of any information about domestic abuse services being shared with Jane.

The review agrees with the IMR author that this was not an organisational failing, as it was an oversight by the duty supervisor for not bringing it to the attention of the DMM.

> On this occasion, as part of her DASH assessment, Jane said that strangulation had occurred in the past.

This relates to the point made earlier; therefore, this is covered by that recommendation.

3.1.18 **2nd September 2020**

3.1.19 The police received a call from Richard. He stated that Jane had assaulted him by punching him to the back of the head and throwing several plates at him, causing pain to the left shin and the head. He also told officers that Jane had smashed his mobile phone a few days previously. Jane was arrested on suspicion of common assault and criminal damage and taken to Torquay Police Station. Whilst she was in custody, Jane spoke to the Mental Health Liaison Worker. Jane was noted as suffering from emotionally unstable personality disorder and not suffering from any psychosis or schizophrenia. During her formal interview with an appropriate adult, Jane admitted to throwing plates at Richard in frustration, as he would not leave her address when she asked him to. Jane presented as being more of the victim. Because of this, and the fact that Richard had not provided a statement, she was released. The crime was filed as No Further Action. Jane was signposted to Torbay Domestic Abuse Services for support. ***This was the first time that she was provided information about domestic abuse services.***

3.1.20 The IMR author has viewed the body worn video of the officers who attended. At the time of Jane's arrest, there is a conversation with her neighbour. Her neighbour said: 'you're not letting him back in are you?', referring to Richard. The officer said that he was not. The neighbour then said that Jane had cats and that she would contact Jane's father. She then

said: 'It's not her it's him. I don't know what he's doing but it's definitely not her'. Richard countered by saying, of his own volition, that the neighbour hated him.

Had a DASH been completed with Richard at the time of the incident, and with Jane in custody once she explained the reason for throwing the plates, further information about the escalating risk could have been collected.

3.1.21 **17th December 2020**

3.1.22 A school contacted the police because they had received 50 emails from Jane. Jane was saying that she was an ex-student of the school. The content of the emails had religious themes and references to 'the end' and 'I'm still here'. Officers attended Jane's home address, where she was found in the company of Richard. Jane was given words of advice about the emails. Jane advised the officers that she would contact her support worker.

A Vulnerability Screening Tool (ViST) risk assessment was not completed for Jane. Force Policy and Guidance directs that any person who is vulnerable that encounters the police, should have a ViST completed. The ViST records the risk and vulnerability and can be shared with partner agencies via the Central Safeguarding Team (CST). Jane was vulnerable due to her mental health, and the nature of this incident should have given the attending officers enough insight into Jane's mental health for them to follow Policy and Guidance. Had a ViST been completed, it could have then been shared with partner agencies (with Jane's consent) to ensure agencies were aware of Jane's continued mental health issues.

Recommendation 2

It is recommended that the Force uses this incident (anonymised) as an example of the type of individuals and circumstances that should attract a Public Protection Notice (PPN). This should then be shared through local learning bulletins.

3.1.23 **7th January 2021**

3.1.24 Jane called the police and repeated her claims of kidnap and taking of her body tissues, as previously reported on 12th November 2020. No officer was deployed to Jane's home address, and she was dealt with over the phone by an officer from the Incident Resolution Centre (IRC). During that conversation, Jane told the officer that Richard was living with her, as a friend. She said that they were getting on well, and he had stopped drinking. He was staying with her because of the COVID-19 restrictions but was out at work during the day. She described her relationship with him as non-intimate and that he slept on the sofa. Jane said that she worried about being murdered by the same people who kidnapped her and took her body tissue from her 20 years ago and that she still sees the vehicle involved, driving around the Torquay area. Jane said that her anxiety was very high now, but she was not feeling suicidal. She said that there was no domestic abuse taking place (with Richard) in her home. She agreed with the officer that she would contact her GP to discuss her anxiety. The incident log was closed.

The review notes the excellent update from the officer who spoke to Jane. Whilst the officer acknowledged that Jane was vulnerable due to her history of mental health and domestic abuse, Jane did not provide any information to suggest that the current risk to her from either had increased. Jane was calm and expressed herself clearly, and she was happy to speak to her GP herself. This was an appropriate and proportionate response to this incident.

3.1.25 **22nd February 2021**

3.1.26 Jane's friend, who lived in Somerset, called the police and reported concerns for Jane. She believed that Jane was being manipulated by Richard and that she was at high risk of suicide. Jane had also told her friend that she had been assaulted by one of Richard's friends and that Richard had punched her in the head. Officers attended Jane's home address the same day and spoke to her. Jane told the officers that she had been assaulted by an unknown male, but it was not Richard. Jane wanted Richard to stop coming to her address and sleeping there.

The attending officers completed all the relevant crime reports and referrals, including a ViST, which is good practice. Whilst the DASH has a risk assessment attached, this is focused on domestic abuse only, whereas the ViST addresses all vulnerabilities. The attending officers clearly identified that Jane had vulnerabilities beyond domestic abuse. *This is an example of good practice.*

> There was an opportunity here for officers to speak to Richard. It is acknowledged that Jane did not name him as the person responsible for assaulting her, but she had clearly articulated her wishes for him to stop coming to her home and sleeping there.
>
> Without any evidence of a criminal offence being committed, the officers would have no legal power to remove him; however, the option was there to speak to him, advise him to leave, and signpost him to housing services, who would provide accommodation.
>
> By not speaking to Richard, he was allowed to remain in the address, causing more anxiety for Jane.

Any DASH graded as medium risk automatically triggers a referral to domestic abuse support services for the area in which the victim resides. This is facilitated and managed through the Victim Care Unit (VCU). However, before that referral can be triggered, the victim must give their consent to share their information. Unfortunately, Jane did not give her consent for her information to be shared; therefore, the referral was never made.

Although Jane had not given her consent for information to be shared, as a matter of routine, she would have been contacted by the Victim Care Unit to discuss support options, including domestic abuse services.

3.1.27 **Impact of COVID-19 restrictions**

3.1.28 Whilst there is evidence that COVID-19 impacted on Jane's mental health (which will be discussed later in this report), there is no evidence that the COVID-19 lockdown impacted on the way in which the police responded to Jane's calls to the police. When there was a need for the police to visit her address, this was done. There is evidence of her being asked if she, or anyone at her address, was displaying symptoms before deploying officers.

3.1.29 There is, however, evidence that the COVID-19 lockdown had an impact of overall service delivery by Devon and Cornwall Police. Local policing was experiencing high demand and low capacity at stages, particularly in July 2020 when Richard was in breach of the DVPO. There was a four-day delay in resourcing and investigating this breach. Whilst this was, in part, due to difficulties in contacting Jane, the impact of this significant delay cannot be underestimated.

3.1.30 **Safeguarding Jane and interventions with perpetrators.**

3.1.31 Jane suffered various levels of domestic abuse throughout her adult life, and this continued with her relationship with Richard. There was continued risk between the two of them, with the police being called on many occasions by both Jane and Richard. It is noted that Jane was unable to support police action beyond the initial call for assistance. The common theme, amongst all the incidents attended by the police, was that she wanted him to leave her home and not stay there anymore.

3.1.32 It is also noted that whilst there was continued risk, that risk never reached the threshold to be considered high and therefore was never referred to MARAC.

3.1.33 We have looked carefully at the opportunities for interventions with the perpetrator of domestic abuse and whether they afforded Jane protection from ongoing abuse. The police, themselves, have identified areas (in the incidents of 2020) where things could have been done differently, and referrals to support agencies could have been better. We have looked specifically at the fact that the clear 'red-flag' of reported strangulation was not identified but are assured that moving forward, the police have improved this area. The police have provided evidence of training that has been introduced to address this area – noting the introduction of non-fatal strangulation being an offence in its own right. We have triangulated the impact of this new approach, and a number of panel members, including those from specialist domestic abuse services, have recognised that the training is having a demonstrative effect in improved recognition of the dangers that victims face.

The review is satisfied that all the incidents of domestic abuse have been subject to scrutiny and that the organisation was consistent in its approach. That approach has continued to improve.

The review has also looked at whether Richard's previous history could have been disclosed to Jane under the Domestic Violence Disclosure Scheme (DVDS), known as Clare's Law. Richard had a recorded history, with Devon and Cornwall Police, of domestic abuse incidents with previous partners before his relationship with Jane. Under the guidelines of the DVDS, this information could have been considered for either a Right to Know or Right to Ask. Any agency could have considered applying to the police for disclosing information about Richard to Jane under the Right to Know. Generally, although not exclusively, this would have been discussed at MARAC; however, Jane's case was never heard at MARAC due to the risk never reaching the threshold to be referred as it was not correctly assessed. There is no record of a DVDS disclosure being considered by Devon and Cornwall Police. Equally, Jane would have been able to apply to the police for a disclosure under the Right to Ask. Again, there is nothing recorded by Devon and Cornwall Police to suggest that this conversation took place with Jane. However, it is noted that Jane was referred to domestic abuse support services in Torbay, and that those services have had that conversation with her.

Whilst any decision to disclose under Clare's Law was ultimately a matter for the police, the above identifies missed opportunities to consider its application.

3.1.34 **Vulnerability**

3.1.35 Eighteen months ago, Devon and Cornwall Police set up the Strategic Safeguarding Improvement Hub. This is a multidisciplinary team that works within a multi-agency environment to identify, develop, and deliver improvements defined by the vulnerability strategy. The hub is responsible for improving police policy, practice, and performance in relation to the 13 strands of vulnerability.[27] Two of these vulnerabilities are: Vulnerable Adults and Domestic Abuse. The hub has staff designated to each of these, and their work is overseen by a Safeguarding Improvement Manager.

3.1.36 The specific issues relating to Jane emailing the police about having taken an overdose and that she had two cats as been the subject of a referral to the IOPC and a subsequent investigation.

3.1.37 Given the nature of that investigation, and its proximity to this review, this DHR has not sought to scrutinise that action. It has been scrutinised by a process of investigation and will likely be subject to further scrutiny during the course of any forthcoming inquest.

3.1.38 Subsequent to that investigation, the following is a summary provided by the police:

An investigation was completed by officers from Devon and Cornwall Police Professional Standards Department (PSD) and the IOPC in relation to two matters. Firstly, the delay in reading Jane's email sent to Devon and Cornwall Police on the day before she was found deceased, and secondly, the lack of a completed DASH following a visit by officers to see Jane on 10th March 2021.

On both occasions, the IOPC concluded that there were lessons to learn, notably that the attending officer (on 10th March 2021) should have considered completing a DASH, given her disclosures of domestic abuse. The officer in question was given management advice around being conversant with current policy when attending similar incidents in the future.

In relation to the delay in reading Jane's email – sent the day before she was found deceased, with details of her suicide plan – the IOPC commented that whilst there are no suggestions Devon and Cornwall Police have been negligent, there is an opportunity to review its reception and triaging process for all incoming emails from members of the public to the Force Enquiry Centre. This issue has recently been further raised at an organisational level, following an inspection by His Majesty's Inspector of Constabulary and Fire Service

[27] The 13 strands of vulnerability, as determined by the College of Policing, will be a key focus to develop this strategy in line with national best practice. These are:
Domestic Abuse
Adult Sexual Exploitation
Stalking and Harassment
Missing and Absent
Female Genital Mutilation (FMG)
Managing of Sex and Violent Offenders
Adult at Risk
Child Abuse
Honour Based Abuse (HBA)
Modern Slavery and Trafficking
Forced Marriage
Serious Sexual Offences
Child Sexual Exploitation
www.cleveland.police.uk/SysSiteAssets/media/images/cleveland/news/2020/mediadocuments/cleveland-police---vulnerability-strategy.pdf

(HMICFRS). Following this inspection, Devon and Cornwall Police have been placed in Special Measures, with the public contact system being an area of specific focus. This work is ongoing to make improvements.

3.2 **DEVON PARTNERSHIP NHS TRUST – Mental Health Services**

3.2.1 Initial contact with Jane was in 1997, when she was 12 years old. She then had regular contact and support from mental health services. She presented frequently with delusions and psychotic behaviour. She had ongoing chronic depression, suicidal ideation, and strong beliefs that she could not recover. Jane had a diagnosis of emotionally unstable personality disorder (EUPD).[28] [29]

3.2.2 At times, over the years, she became disengaged from community mental health services. From December 2019, Jane's care was provided by her GP: this was following a discussion with the MDT, as Jane was not engaging with treatment or responding to attempts to contact her. It was agreed that her GP would re-refer her if it was felt that Jane required treatment in the future.

3.2.3 The last recorded contact with mental health services was in March 2021, after the police contacted the First Response team because they were concerned about Jane's welfare, as she was expressing suicidal ideation. The First Response team called Jane on 11th March, and it was noted that low mood was evident, with suicidal ideation; however, Jane said that she was seeing her GP later in the day. She informed them that she was using Mental Health Matters and knew who she could contact. The information was provided to her GP.

3.2.4 Jane had a number of risk assessments that ranged from low to high, depending on her mental health at the time. There is evidence that the risk assessment was discussed, and that Jane did not recognise that she was mentally ill. Furthermore, at times, she did not wish to access mental health services. Due to the complexities that Jane's condition presented, services found her to be a challenging person to engage with. This comment does not in any way place the blame on Jane, but it is a fact that the context, in which services were working with her, was challenging. Disengagment from services is recognised as a risk factor within the Trust's own policy[30].

3.2.5 **Trauma**

3.2.6 DPT was specifically asked to consider whether trauma was ever considered to have been a contributory factor to her mental health.

3.2.7 In 2010, Jane had a period of inpatient care in a Tier 4 facility.[31] This was followed by a further placement in a therapeutic community, under the overall care of a medical psychotherapist: a consultant psychiatrist who is also a specialist in psychotherapy. The records indicate that Jane may have completed a course of dialectical behavioural therapy while in the Tier 4 placement and then engaged in psychotherapy in the therapeutic community. Both placements were hosted by private providers, and commissioned by the Clinical Commissioning Group, so the daily clinical notes are not available. The reports

[28] https://www.mind.org.uk/information-support/types-of-mental-health-problems/borderline-personality-disorder-bpd/about-bpd/
[29] Jane's family also told the review that she had a diagnosis of schizoaffective disorder but this is not confirmed by the records available to this review.
[30] https://www.dpt.nhs.uk/resources/policies-and-procedures/risk/clinical-risk-assessment-and-management
[31] Enhanced care suitable for those presenting with complex needs and in need of a containing environment and therapeutic input.

submitted by the providers do not go into a sufficient level of clinical detail to specify whether Jane was asked about trauma and traumatic experiences. However, given the nature of these environments and the therapeutic approaches employed, the IMR author believes that it seems highly likely that there would have been enquiries into Jane's early life and whether she had experience trauma. Therapy at this depth, usually seeks to explore the relationship between a person's past experiences, their personality, and how this affects their present.

3.2.8 In 2012, Jane was offered a place on a RELAY group – a therapeutic group intended to help a person to develop their distress tolerance and emotional resilience. The intervention is informed by dialectical behavioural therapy and was frequently offered to people who had experienced trauma, and particularly those who had been subjected to pain at an early age by another person. Although the clinical records do not state specifically that trauma was considered, the relationship between trauma and mental illness is well known and forms part of the clinical thinking in treatment. The IMR author stated that it would be very surprising if the clinicians (involved in Jane's treatment) did not consider trauma.

3.2.9 **Treatment**

3.2.10 DPT was asked if Jane's treatment may have been different if her experience of trauma was known, and if so, in what way.

3.2.11 The IMR author confirmed that Jane was offered several psychological approaches to improve her mental health. These included the following: psychotherapy, a therapeutic community approach, cognitive behavioural therapy, dialectical behavioural therapy, and compassionate minds therapy. She spent time in supported living and had a psychosocial approach to living – offering incremental interventions in the context of her life.

3.2.12 The treatments that Jane was offered were suitable for her presenting needs and are evidence-based approaches recommended by NICE for the treatment of the disorders that Jane presented with. If Jane's experience of childhood sexual abuse had been known, she might have been facilitated to access a service that met that need specifically. For example, Devon Rape Crisis.

3.2.13 **The underlying causes of Jane's mental ill-health**

3.2.14 When asked if it was felt that enough was done to understand the underlying causes of Jane's mental health, the IMR author advised the review that Jane had a number of assessments of her mental health, in a variety of settings. These assessments cover the biological, psychological, and social factors that are understood to contribute to a person's mental health. Further to this, Jane engaged in several interventions that would have included exploration of her thoughts and feelings and why they occurred. A part of these interventions is to try to develop a hypothesis about why the difficulties occur.

3.2.15 During a community assessment in 2017, Jane was asked a number of questions (below).

Sexual Abuse	
Evidence of Sexual Abuse?	No
Jane denies a history of sexual abuse but stated that she once experienced distortions in her memory, which made her feel that this is true.	

3.2.16 Further questions about trauma in relationships were asked:

Domestic Abuse	
Evidence of Domestic Abuse?	No
No historical information available.	

Physical Abuse	
Evidence of Physical Abuse?	No
No historical information available.	

Emotional Abuse	
Evidence of Emotional Abuse?	Yes
Jane reports a history of emotional abuse from her mother during childhood. However, Jane and her mother are currently meeting regularly and are trying to rebuild their relationship.	

3.2.17 These topics were repeated in subsequent assessments of Jane's mental health. In an assessment by Liaison Psychiatry, in March 2020, further information was disclosed:

Personal history
Brief summary of patient's personal history.
Jane lives in xxxx, and has lived in Devon since childhood, her parents separated when she was 8 years old and at 11 years old, she made allegations of emotional and physical abuse (details redacted). Between the ages of 13 and 17 years, Jane was looked after in local authority care, and within mental health services. She has been known to mental health services since 1997, and she was first admitted to hospital at 12 years old. Jane was admitted to hospital frequently under both civil sections and s.37 MHA. Her last admission was in 2011. She was discharged onto a CTO[32] and this was subsequently rescinded. Jane has engaged with mental health services in the past. However, she has disengaged from more recent contact with community services, preferring to be supported by her GP and medications.

3.2.18 As these questions related to historic assessments, the IMR author was asked to comment on whether Jane would be treated differently if she presented to services for the first time now. The IMR author responded by saying that this is unclear. Although the appreciation of trauma has grown in recent years, Jane's records show that evidence-based interventions were offered, and these were sensitive to the experience of trauma contributing to mental-ill health.

3.2.19 Whilst services for survivors of sexual abuse and rape have grown, Jane accessing these services would have been dependent upon her having disclosed this to a clinician.

For the sake of clarity, the review has seen no evidence, nor do we believe that Jane ever made any suggestion that any trauma had resulted from familial sexual abuse. Rather, it is likely that the abuse she spoke about was her disclosures in later life of being sexually abused by a boy whilst she was in her early teens.

3.2.20 **Impact of COVID-19 restrictions**

[32] Community Treatment Order

3.2.21 Due to the COVID-19 pandemic, Jane expressed a preference for remote contact; therefore, from 4th August 2020, all of Jane's appointments were moved to telephone or video calls. That said, in-person visits were made when she did not respond to phone calls.

3.2.22 Jane expressed a desire to start yoga and swimming, as well as making friends, but she was not able to do this due to restrictions.

3.3 TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

3.3.1 Drug and Alcohol Service

3.3.2 Jane had two episodes of treatment from the drug and alcohol service: in 2015 and in 2019. On both occasions, Jane discharged from the service after a relatively short time, saying that she was no longer using substances. On the third occasion, a referral was made by Jane's GP, but she did not engage with the service.

In 2021, the service introduced a new aftercare closure form for all individuals who encounter the service – to provide a more robust approach to discharge. This would not have benefitted Jane, but it demonstrates that the service continues to implement a robust aftercare package and develop support for those with addiction issues outside of the service.

3.3.3 Emergency Department – Torbay Hospital

3.3.4 10th January 2020

3.3.5 Jane attended the ED at Torbay Hospital, where she needed a mental health assessment. When triaged, it was noted that the initial complaint was unusual behaviour, and it was also noted that she needed a mental health review. The comments at triage were: 'Suffered with psychosis and depression, getting progressively more disturbed, thinks losing touch with reality, not trusting own family, selling jewellery. Trying to get mental health appointment but unable to see them for three months.'

Unfortunately, when Jane arrived at the ED, staff did not ring the mental health team to request the assessment; therefore, Jane was in the waiting room for six hours and was not seen by anyone. As soon as the delay was identified, the call was made.

The review agrees with the IMR author that best practice would have been for the mental health team to have been contacted immediately after Jane's risk assessment. The review acknowledges that as soon as the delay was noted, immediate action was taken. Jane was supported and kept comfortable until she was transferred to an appropriate area.

3.3.6 25th February 2020

3.3.7 Jane was taken by the police to ED at Torbay Hospital (arriving on 26th February), as Jane's partner had called 999 after Jane had stood over him in bed with a knife, threatening to kill him. She presented at ED with unusual behaviour and was accompanied by the police. Jane said that she had thoughts of people removing her stomach when she was awake (with no pain relief) and that the army were working undercover as cleaners and were trying to kill her. She said that her partner consumed alcohol and was often in an intoxicated manner.

He would then tell Jane something that led her to believe her own thoughts and feelings. She openly said that she did not trust him and had regular thoughts about hurting him. She said that she did not have thoughts to hurt herself but did have previous thoughts about harming the public. It was noted that Jane's medication was mirtazepine, venlaflaxine, olanzepine, levothyroxine, diazepam, and lorazepam. She said that she had missed three doses of her venlaflaxine. Jane disclosed that, due to anxiety and fibromyalgia, she had not been out of the house properly for eight months.

3.3.8 It was reported that Jane had missed three doses of her medication. Jane was seen by Liaison Psychiatry. This is the hospital based mental health team that provides assessment for patients attending general hospitals. The plan was for a mental health admission under Section 2/voluntary admission, and it was noted that she was a high-risk patient who needed one-to-one support in the Clinical Decision Unit (CDU).[33] Jane was admitted from CDU: the mental health unit at Weston-Super-Mare.

The review notes that a mental health bed was found promptly and that the appropriate transfer was made. Jane was comfortable, and her needs were met whilst she waited for the transfer.

3.3.9 **Safeguarding referral – 18th February 2020**

3.3.10 Safeguarding concerns were raised by a school, who reported that Jane had been sending excessive emails (approximately 50), and the content of the emails (religious themes and references to 'the end', 'goodbye', 'I'm still here') was concerning. The school asked that a welfare check needed to be done. A safeguarding referral was made to the Single Point of Contact (SPOC), which receives safeguarding referrals from Torbay. The service that SPOC sits within, is Adult Safeguarding in Torbay and South Devon NHS Foundation Trust.

3.3.11 Devon Partnership Trust was made aware on 11th January 2021. The SPOC advised that Jane's father and GP were protective factors. The SPOC spoke to Jane's father, who said that he had daily contact with Jane by phone and that he was of the view that Jane was currently presenting well. ***This is an example of good practice to speak to Jane's father.*** No further action was taken by the SPOC, but they recommended that mental health undertake a welfare check.

This alert was not handled within the required timescales. The review is aware that, on 18th December 2021 when Jane's referral was received, there were 34 outstanding referrals – all had been risk assessed, but not allocated. Seven referrals were received in total on 18th December – all were risk assessed, but none were allocated until 20th December and 4th January 2021. Between 18th and 31st December 2021, the SPOC received 17 other referrals that were risk assessed as having a higher prioritisation for allocation than Jane's, based on the information supplied at the point of contact.

[33] The Clinical Decision Unit is a bedded area in the emergency department, sometimes used for those people that need to be sectioned under the Mental Health Act.

The review is aware that, since the time of this referral, Torbay and South Devon Foundation Trust has reviewed and made changes to the SPOC service, which has resulted in a staff increase and quicker response times.

The review is advised that, given the information on the referral form and the changes in the SPOC structure, if the same circumstances occurred today, the prioritisation would unlikely have changed; however, the response time would likely have improved.

3.4 **JANE'S GP**

3.4.1 Jane had been registered with the practice prior to the scope of this review. She engaged well with the practice, attended her regular reviews, and frequently called to discuss any concerns she had.

3.4.2 **Assessing and managing risk**

3.4.3 When reviewing their care of Jane (after her death), the practice discussed that, in the days prior to her death, the risk that Jane posed to herself was considered to be low. She had a long history of similar episodes, and the practice considered how they could, in future, establish when the risk levels had increased to cause a concern.

3.4.4 The practice has considered how they can flag a deterioration in patients who have Severe Mental Illness (SMI) and acknowledges that there needs to be a lower threshold for raising concerns about, and following up with, these patients. The challenge that this poses is highlighted by Jane's presentation before her death, which was consistent with how she had presented previously, and there was nothing unusual about this.

3.4.5 Early in 2020, the practice set up monthly Adult MDT (multidisciplinary team) meetings, to which mental health services were invited. Jane would have been discussed at this meeting if there had been a new concern raised.

3.4.6 The practice has also introduced weekly meetings with the mental health teams attached to the practice: this has resulted in the threshold being lowered for referring patients into secondary mental health services.

3.4.7 It was noted that Jane, in early 2020, had regularly been seen and followed up by the same GP who knew her well. However, due to the changes required due to the COVID-19 lockdown, it was not possible to provide this same continuity of care, and she was, therefore, seen by other members of the practice. The practice has reflected on the deterioration in patients when many GPs are involved in their care; therefore, it has changed its appointment system to allow for more continuity.

3.4.8 Whilst Jane had informed the practice that she would not be attending an appointment (shortly before her death) and had given the reason, the practice has recognised the need for a low threshold for raising concerns about patients with multiple complex needs, or who are in some other way more vulnerable, that do not attend for an appointment.

The review notes that the practice has introduced a revised Did Not Attend (DNA) protocol for children and vulnerable adults that applies to those on the SMI (Severe Mental Illness) register.

3.4.9 **Mental health medication reviews**

3.4.10 The practice has reviewed the process for mental health medication reviews. This will ensure that there is a shorter time between reviews when concern has been raised about medications or the patient is on weekly or fortnightly prescriptions.

3.4.11 Similarly, there has been a change in the way that decisions to increase the quantity of prescriptions are actioned. The new process will ensure that a GP authorises changes to the prescriptions either by a 'task' or a telephone call. This will be a change from the previous process of a note being placed on the script request.

3.4.12 The prescription team in the practice pharmacy are being trained to ensure that concerns are raised in an appropriately and timely way.

3.4.13 **Routine questioning about domestic abuse and relationships**

3.4.14 The practice has considered their Mental Health Review process and if they should consider a person's vulnerability, and more directly, ask about their social circumstances and personal relationships as part of these routine reviews.

Jane had never been asked specifically about domestic abuse. When she was seen for contraception in 2020, there were no questions asked about her relationship status.

The review has been advised that the practice has implemented a new mental health review template that includes a specific section about who is in the patient's household.

The GP practice is implementing a 'lower threshold' for asking about domestic abuse and adding the code 'domestic violence discussed', if any concerns are raised.

3.4.15 The consultation time with Jane was focused on her immediate, presenting health needs; therefore, due to the frequency of appointments when Jane presented with acute needs, there was little space for clinicians to explore the wider context.

The practice identified that Jane's mental health problems may have impacted on her ability to disclose domestic abuse and may have been seen as a reason for her physical problems.

3.4.16 With hindsight, the practice acknowledges that the fact that Jane's father was a positive presence in her life, may have given the impression that Jane had the appropriate levels of support and so was not explored further.

Devon Integrated Care Board (ICB) has noted that a number of Devon DHRs relate to suicide, and that in several cases, the suicidal ideation of the deceased was known to the GP. This has raised whether GPs have sufficient training and information to enable them to assess suicide risk accurately. Devon ICB will be collaborating with local partners to explore and improve understanding and prevention of suicide in the context of domestic abuse.

In order to improve its approach to domestic abuse, the practice has implemented the following:

- **The Domestic Abuse and Sexual Violence Policy has been circulated to all staff in the practice. The policy supports proactive clinical enquiry.**
- **The practice has lowered the threshold for asking about domestic abuse and uses a code to flag any domestic abuse concerns.**
- **The ICB will be delivering training to the practice to increase clinical enquiry.**

It is also noted that the practice has expressed an interest in being an early adopter of the new Interpersonal Trauma Response Service.[34]

[34] https://www.fearfree.org.uk/itrs-for-professionals/

Section Four – What do we know about Jane?

4.1 Background

4.1.1 When she was well, Jane was extremely artistic and graceful, and she could be very sociable. She was bubbly and funny. She dressed in expensive, stylish clothes and ensured that her hair and make-up were done well. Her friend described her as the 'best cook ever'.

4.1.2 Jane was described as kind and generous, and this often led to her being taken advantage of. She made friends with those who were homeless and often sought to help them. In 2013, she befriended a woman in a park and lent her £1250. She subsequently found out that the woman was a heroin user. Her father spoke of Jane befriending people with learning disabilities, as she thought that she could help them, for example, taking them shopping.

4.1.3 All those that spoke to the review said that Jane was devoted to her cats. Her father described them as number one in her life, and he could not understand how she had left them behind.

4.1.4 Jane's friend said that her family were her life and kept her going.

4.1.5 Jane lived with her parents until they separated when she was eight years old. At the age of 11, Jane reported what she felt were the difficulties of living at home.[35] Between the ages of 13 and 17, Jane was looked after in local authority care and within mental health services. She was known to mental health services from 1997 and was first admitted to hospital at the age of 12. Jane was admitted to hospital frequently under both civil sections and Section 37 of the Mental Health Act. Her last admission was in 2011, when she was discharged onto a Community Treatment Order that was subsequently rescinded. During this admission, it was noted that there was a possible schizoaffective disorder with moderate to severe depression at times, as well as emotionally unstable personality disorder. Jane had engaged with mental health services in the past; however, she had disengaged from more recent contact with community services, preferring to be supported by her GP and medications. Jane's diagnosis was recorded as emotionally unstable personality disorder.

4.2 The vulnerabilities that Jane faced

4.2.1 Jane was a bright young girl who had attended grammar school but had struggled with psychological issues. Her mother recalls that the problems began when Jane was about 10 – 12 years old, when she began to self-harm and to take cannabis. It was after she was discovered self-harming in the toilets at school that Children's Social Care (CSC) was, appropriately, involved by the school.

4.2.2 Jane's mother believes that her exclusion from school may have led to her feeling rejected and abandoned.

4.2.3 Jane was placed in a mental health setting by CSC, and she continued to self-harm by cutting herself on her legs, arms, stomach, neck, and face.

4.2.4 Jane's father said that he knew that she was having underage sex, and he believed that this had impacted on her sense of self-worth.

[35] The review is aware of the nature of these comments, but they are not repeated here out of respect for Jane and her family.

4.2.5 The Chair and Report Author are aware that Jane experienced a traumatic event in her early teens. This is dealt with elsewhere within this report, and the trauma of it is acknowledged as having a significant impact upon her.

4.2.6 It is clear that Jane did not cope well with her parents' separation.

4.2.7 Jane appeared to be aware of the challenges that she faced. She had told her mother that she would never have children because 'I cannot do that, it would not be fair'. Furthermore, Jane was worried that any child she may have, would be taken into care due to her mental health issues.

4.2.8 Jane's mother said that Jane had grown up in the system and never managed to adjust to ordinary life as an adult. Both Jane's parents said that Jane told lies and that you could not be sure if what she was saying was true.

4.2.9 Jane's father spoke of the difficulties that she faced when she transitioned from children's-based services into adult services. He said that the 'worst experience possibly that she had was when she was transferred into an adult unit at a hospital in the South of England. There she became anorexic, dropping down to around five stone, she then had a considerable amount of electric shock treatment'.

4.2.10 Jane's mother described her as being fragile but putting on an act of being fine. She was not able to keep her flat well; therefore, at times, her mother would do her cleaning.

4.2.11 Jane's brother spoke of her having very little structure in her life. This concurred with the mental health assessment in 2016, when it was noted that Jane had spent much of her adult life in the mental health system and found it hard to believe that she could exist outside of the system. She lacked a weekly structure and purpose in her life.

4.2.12 After experiencing abuse in 2015, it was noted that Jane felt sorry for people with problems, and she said that she felt isolated and vulnerable.

4.3 Evidence of domestic and sexual abuse

4.3.1 The Domestic Homicide Review is charged with seeking out the trail of domestic abuse. To assist in understanding Jane's vulnerability to abusive partners, a brief history outside the scope of this review is included. This review fully recognises the impact of the traumas (outlined below) upon Jane.

4.3.2 **Outside the scope of the review**

4.3.3 In 2013, Jane reported that a person, with whom she was in a relationship, had raped her. She said that although she had reported the rape, she did not feel that she could cope with pressing charges. She said that this man had made threats to kill her, to burn down her flat, and had damaged neighbours' cars, leading to her being asked to leave by her landlord.

4.3.4 In 2015, Jane reported financial abuse and being coerced into sending a sexually explicit video of herself to a friend who intended to use this to defraud men of money. This was reported to the police.

4.3.5 In 2016, it was noted that Jane had a history of being exploited by others, both sexually and financially, and with a history of bullying.

4.3.6 Within the scope of the review, the first record of Jane referring to being in an abusive relationship was in January 2020, when she said that she was in an abusive relationship and that her partner had threatened to rip her organs out.

4.3.7 In February 2020, the police were called by Richard. He reported that Jane was threatening him with a knife. When she was taken to hospital, Jane said that her partner was receiving money to stay with her so that he could cover up her death. She said that he was linked to the 'bad people' who were looking to physically harm her, take her organs (without pain relief), and eventually kill her. She was, on this occasion, detained under the Mental Health Act.

4.3.8 **Coercive control**

4.3.9 Jane's friend said that she and Jane had to be careful what they said to each other in texts, in case Richard was reading them.

4.3.10 Jane's friend said that Richard would continually tell her that he was going to kill her.

4.3.11 Jane's father said that he would not allow Jane to change the TV channels (despite it being her TV in her flat), and when her father questioned her about why she stayed with him, she said that she loved him.

4.3.12 In February 2020, the police were called by Richard, as he said that Jane had a knife. Although she did not disclose to the police at the time, Jane later told her mother that Richard had been threatening to have her sectioned, and he was telling her that she was 'mad'. She said that she had therefore had to defend herself and had taken the knife to keep him away from her.

4.3.13 **Verbal abuse**

4.3.14 Jane told the police, in March 2020, that her partner was abusive to her, especially when he had been drinking.

4.3.15 When her partner turned up at her home in May 2020, Jane let him in, and a verbal argument began. Jane asked him to leave.

4.3.16 **Isolation**

4.3.17 Jane's mother said that she would regularly arrange to see Jane; however, during the time that she was with Richard, she saw her less often. Prior to this relationship, Jane's mother would visit, and Jane would be keen to make lunch.

4.3.18 Her friend said that Jane stopped talking to her friends, and when she did see Jane, she was continually checking her phone.

4.3.19 She said that Jane was not allowed out much and that Richard went everywhere with her.

4.3.20 **Gaslighting**

4.3.21 Richard would encourage Jane to believe the voices that she was hearing. This included, for example, 'you're a slut' and 'you're a whore'.

4.3.22 **Economic abuse**

4.3.23 Jane disclosed, in March 2020, that her partner had taken her bank card and purchased alcohol, as he had been drinking all day.

4.3.24 **False imprisonment**

4.3.25 On 3rd June, Jane told the police that, six weeks earlier, Richard had held a knife to her and had refused to let her leave her property. She said that he had tried to kiss her.

4.3.26 **Separation**

4.3.27 On 23rd March 2020, Jane said that she and her partner were no longer in a relationship and that he was no longer living with her.

4.3.28 On 26th March, Jane said that she was not going to allow her partner back into her house.

4.3.29 The next reference to her partner was on 24th May 2020, when he had turned up at her home, in drink.

4.3.30 **Stalking and harassment**

4.3.31 Jane called the police on 3rd June because Richard was outside her home and was constantly ringing her doorbell. He had left when the police arrived.

4.3.32 On 9th June, Jane reported to the police that Richard had been at her house the previous night (in the early hours) and had been banging on her door. He had also been calling her mobile.

4.3.33 On 14th June, Richard was outside her property (drunk), and he was arrested.

4.3.34 On 21st June, Richard breached the DVPO by calling her at 1.30 am.

4.3.35 On 10th July, he appeared in court and was found guilty of the breach: he was given a formal warning.

4.3.36 On 12th July, Jane called the police because Richard had contacted her (on the phone) 20 times, saying how much he loved her.

4.3.37 On 2nd September, Jane was arrested after Richard reported to the police that she had punched him in the back of the head and had been throwing plates at him. In interview, Jane admitted throwing the plates and said it was because he would not leave her home when she had asked him to. It was deemed that she was the victim, and no further action was taken against her.

4.3.38 On 12th September at 3.27 pm, Jane rang the police to report that Richard had been knocking on her door at 3 am. He sent her a text, asking for money for drugs. When Jane refused, he left and sent her a threatening text message, saying: 'I will cut your throat'.

4.3.39 On 17th October, Jane called the police because Richard had arrived at her home and refused to leave. When the police arrived, he continued to refuse to leave and said he would keep coming back all night. He was arrested to Prevent a Breach of the Peace. He was released the following day, as he was now sober.

4.3.40 By 10th November, Jane told a RMN that Richard was now her best friend and was supporting her. She said that he was doing really well and that he had been an alcoholic but was no longer drinking.

4.3.41 On 7th January 2021, Jane told the police that Richard was now living with her 'as a friend'. She said that they were getting on well and that he had stopped drinking. She said that Richard was not being abusive towards her at that time.

4.3.42 On 22nd February, Jane's friend rang the police to report that Jane was being abused by Richard. She said that he kept going to her home, with his friends, and he was staying there all night, despite being asked to leave. She said that Jane was being manipulated by him and that he had punched her in the head. When the police attended, Jane said that she wanted Richard to stop coming to her home. It was noted that the house was messy, with alcohol bottles left around. Jane said the bottles were Richard's, and due to her health conditions, she was unable to clean up.

4.3.43 On 15th March, police officers attended Jane's home and found Richard there. He had packed his belongings and had said that he was waiting for a lift. Jane said that she wanted him to leave immediately. He left, with plans for someone to collect the rest of his belongings later. The officers stayed with Jane to ensure that he did not return, and advice was given to her about keeping her front door locked and not letting him in.

4.3.44 When Jane told her friend about the relationship, she advised her to get away from him, but she said that Jane had said that she loved him. The friend said that Richard controlled everything, and whenever he was abusive to her, Jane blamed it on the drink. She described Jane as being dependent on him.

4.3.45 **Physical abuse**

4.3.46 In March 202O, Richard called the police once again, as Jane had a knife and was threatening to stab him. When the police arrived, Richard had left. Jane disclosed that her partner had assaulted her by kicking her to the side of her body and placing his hands around her throat, strangling her for 10 seconds.

4.3.47 Her mother also said that Jane had told her that Richard had held her up against the wall by her neck.

4.3.48 **Non-fatal strangulation**

4.3.49 For ease of reading, the disclosure of non-fatal strangulation is set out above, under 'Physical abuse' (4.3.46). However, due to its seriousness, it is considered here in more detail.

4.3.50 68% of high-risk victims of domestic abuse will experience non-fatal strangulation by their partner.[36]

4.3.51 The danger that non-fatal strangulation poses cannot be underestimated. Casey Gwynn[37] has said that this is the 'last warning shot', and women are six times more likely to be become a victim of attempted homicide and seven times more likely to be murdered after strangulation.[38] He says that men who strangle women are the most dangerous on the planet.

The review notes that the DASH risk assessment includes a question about strangulation, but if the victim answers 'yes', this will count as one tick, as will the answer to every other question. The review does not consider that this adequately reflects the risk that strangulation poses. A recommendation has been made earlier in this report.

4.3.52 Research has demonstrated that strangulation is often used as a tool to exert power and control and instil fear rather than a failed homicide attempt.[39] Men who strangle, want the woman to know that he has her life in his hands and that he could kill her at any point.

4.3.53 Women who experience non-fatal strangulation are at high risk – with the potential to be murdered in a future violent event, by the same perpetrator, significantly increased.[40]

4.3.54 The true extent of the harm and risk caused by non-fatal strangulation is not accurately understood, as many women do not seek assistance after an incident. Furthermore, for those who do, there may be no obvious physical injuries – with only half of victims having visible injuries and, of these, only 15% could be photographed.[41]

4.3.55 A woman who experiences non-fatal strangulation is unlikely to fully understand the long-term consequences on them. Even if a woman is not murdered by strangulation, they may have internal injuries, and the non-fatal strangulation can lead to complex medical conditions.

4.4 Trauma

4.4.1 We know that Jane had experienced trauma in her childhood/teens, and the review has sought to understand how any potential trauma was considered by services. A number of questions were asked of Devon Partnership Trust: the provider of mental health services at the time of Jane's death.

4.4.2 **Was the impact of trauma considered in the services that Jane received from mental health services?**

[36] Strangulation in Intimate Partner Violence, Training Institute of Strangulation Prevention, v6.24.19
[37] Strangulation Training Institute, https://www.allianceforhope.com/ Quoted from Strangulation: The Last Warning Shot training in June 2022
[38] Nancy Glass, J Emerg 2008 35(3) cited at ibid.
[39] Thomas, Joshi and Sorenson, 'Do you know what it feels like to drown? Strangulation as coercive control in intimate relationships, 2014 cited in the Centre for Women's Justice submission on the Domestic Abuse Bill, January 2021
[40] Lovatt H, Lowik V and Cheyne N, The voices of women impacted by non-fatal strangulation, Queensland Centre for Domestic and Family Violence Research, CQUniversity, Australia, 2022
[41] Strangulation in Intimate Partner Violence, Training Institute of Strangulation Prevention, v6.24.19

4.4.3 Jane received a number of placements:

- Inpatient care in a Tier 4 facility (enhanced care suitable for those presenting with complex needs and in need of a containing environment and therapeutic input) in 2010.
- A further placement in a therapeutic community, under the overall care of a medical psychotherapist – a consultant psychiatrist who is also a specialist in psychotherapy.
- Jane appears to have completed a course of dialectical behavioural therapy while in the Tier 4 placement and then engaged in psychotherapy in the therapeutic community.

4.4.4 Both placements were hosted by private providers, and commissioned by the Clinical Commissioning Group, so the daily clinical notes are not available. The reports submitted by the providers do not go into a sufficient level of clinical detail to specify whether Jane was asked about trauma and traumatic experiences. However, given the nature of these environments and the therapeutic approaches employed, the review is advised that it seems highly likely that there would have been enquiries into Jane's early life and whether she had experienced trauma.

4.4.5 Therapy at this depth, usually seeks to explore the relationship between a person's past experiences, their personality, and how this affects their present.

4.4.6 In 2012, Jane was offered a place on a RELAY group – a therapeutic group intended to help a person to develop their distress tolerance and emotional resilience. The intervention is informed by dialectical behavioural therapy and was frequently offered to people who had experienced trauma, and particularly those who had been subjected to pain at an early age by another person. The review is advised that although the clinical records do not state specifically that trauma was considered, the relationship between trauma and mental illness is well known and forms part of the clinical thinking in treatment. The IMR author told the review that they would be very surprised if the clinicians (involved in Jane's treatment) did not consider trauma.

4.4.7 **How might Jane's treatment have been different if her trauma had been known about?**

4.4.8 Jane was offered several psychological approaches to improve her mental health. These included the following: psychotherapy, a therapeutic community approach, cognitive behavioural therapy, dialectical behavioural therapy, and compassionate minds therapy. She spent time in supported living and had a psychosocial approach to living – offering incremental interventions in the context of her life.

4.4.9 The treatments that Jane was offered were suitable for her presenting needs and are evidence-based approaches recommended by NICE for the treatment of the disorders that Jane presented with.

4.4.10 **Was enough done to try and establish the underlying causes of the mental ill-health?**

4.4.11 Jane had several assessments of her mental health, in a variety of settings. These assessments covered the biological, psychological, and social factors that are understood to contribute to a person's mental health. Further to this, Jane engaged in several interventions that would have included exploration of her thoughts and feelings and why

they occurred. Part of these interventions is to try to develop a hypothesis about why the difficulties occur.

4.4.12 **Would Jane's treatment be different if she presented now?**

4.4.13 Though the appreciation of trauma has grown in recent years, Jane's clinical record show that evidence-based interventions were offered, and these were sensitive to the experience of trauma as contributing to mental ill-health.

4.4.14 **TRAUMA-INFORMED PRACTICE**[42]

4.4.15 Trauma-informed practice is a way of working that responds to the evidence that trauma is evident in the population, and the knowledge around the potential impact on people who experience trauma.

4.4.16 Trauma-informed practice changes the narrative from 'something is wrong with this person' to 'something has happened to this person, and they have a story of adversity that has traumatised them'.

4.4.17 **THE APPROACH IN TORBAY**

4.4.18 From October 2021 to March 2023, a project manager for trauma-informed approaches was employed in recognition of the importance of this area of work. Furthermore, that there were pieces of work underway that would benefit from co-ordination.

4.4.19 It was recognised that, for example, in the Youth Justice Service, trauma-informed practice was already well established, and there were other areas where it was emerging.

4.4.20 **TRAUMA-INFORMED PRACTICE PROGRAMME**

4.4.21 This programme was delivered to staff who work in services where they are likely to be working with people who have experienced trauma. The programme ran over eight months and combined information, skills, and opportunities to reflect on practice. The programme was delivered by a local organisation, Zebra Collective, who specialises in work around trauma and trauma-informed practice.

4.4.22 In 2021, 85 people – who work with those experiencing homelessness – participated in the programme. With funding from the Community Safety Partnership and Public Health, 250 staff participated in 2022. These came from:

- Police
- Fire
- Probation
- Drug and alcohol services
- Domestic abuse support services
- Sexual health services
- Health visitors and school nurses

[42] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

- Senior Leadership Team and Council Leader from Torbay Council

4.4.23 The programme is made up of eight sessions over approximately eight months. The sessions used a variety of learning methods, such as video/presentations and reflective sessions.

4.4.24 Evaluation of Phase 1 of the programme was undertaken. This was light touch, as the funding for evaluators was only secured part way through the programme. Funding has now been secured for a full evaluation of later programmes.

4.4.25 The evaluation was set up to:

- Explore 'how does this work and for whom?' rather than 'does this work?
- Support Zebra/Torbay Council in service evaluation through development of 'logic model'/theory of change
- Be a rapid qualitative enquiry to develop useful learning to inform the next delivery of the programme and evaluation.

4.4.26 The key findings were:

- That 80% of workshop participants attended sessions 1 – 3, and 70% attended sessions 4 – 6
- There was a decline in attendance for the final two reflective sessions – with 52% of participants attending session 7, and 48.6% attending session 8
- Reasons given for non-attendance included – leave or sickness, work-related capacity issues, moving to new roles
- Three participants across the whole cohort either did not attend or left early due to finding the sessions too triggering.

4.4.27 Participants in a focus group, reported changes in their practice because of attending the programme:

- Greater focus on relationship building, through active listening and recognising and avoiding the need to 'fix' issues
- Developing a greater empathy and shifts in language use
- Validation of current practice
- Personal impact.

4.4.28 The focus groups identified a number of organisational issues:

- Potential increase in cohesion across the sector
- Some shifts in processes – a desire to make systems work for people as opposed to vice versa
- Sense of pride in the council's commitment, especially given current circumstances
- Frustration and perceived limitations in some roles
- Some concern over whether this was the appropriate approach at all.

4.4.29 Overall, there was evidence from attendees of positive shifts towards more relational, trauma-informed practice as a result of attending the programme. However, some people found it a challenge to become more trauma-informed, sometimes due to a feeling of role restriction. Senior management involvement was identified as being important.

4.4.30 **WIDER WORK IN TORBAY**

4.4.31 The **Trauma Informed Network Torbay (Embrace)** brings together people from across a range of agencies, from both the statutory and voluntary sector. It provides an opportunity to connect the trauma-informed work across Torbay, developing standard approaches and training and sharing good practice. It currently has approximately 200 members.

4.4.32 The **Trauma Informed Practitioner Group** meets once a month to support embedding trauma-informed practice.

4.4.33 The **Embedding Trauma Informed Practice Group** has come out of this programme. Those who had been on the programme expressed a desire to ensure that the learning from the programme was kept alive. Participants in the group are 'Trauma Informed Practice Leads' and promote a 'trauma-informed lens' with colleagues and within their teams.

4.4.34 Once a month, the **Trauma-Informed Strategic Group** meets to look at trauma-informed leadership and practice in strategic roles, such as commissioning and procurement.

4.4.35 **Web pages** are being designed that will contain information, resources, and Level 1 training.

4.5 The impact of COVID-19 lockdown

4.5.1 Jane's father recalled that lockdown was very difficult for Jane. She had stayed with him for 4 – 5 weeks and maintained telephone contact with Richard. Jane had moved back to her flat, and they returned to seeing each other regularly, as living with her father had not worked out because they were so different – he liked to live in a very tidy home.

4.5.2 When Jane returned to her own flat, she was living with Richard; however, this caused her to be very fearful because she was out and about and not taking care with social distancing. She had told her father that she would be able to see him in the next week, as she would have had her vaccinations.

4.5.3 Jane told her friend that she felt lonely and isolated but felt too scared to leave the house. Her friend described how, during this time, Jane was focused upon herself and did not ask about her friend, which was very unlike her.

4.5.4 On 15th April 2020, when Jane's care plan was commenced, she indicated that she would like to be able to attend yoga and swimming; however, due to lockdown, this was not possible at the time. She also said that she would like to make some new friends.

Section Five – Suicide and Domestic Abuse

5.1 Prevalence

5.1.1 The number of Intimate Partner Abuse Related Suicides (IPS) is not formally counted in England and Wales. The ONS (2019) reported that, on average, 30 women took their own lives each week in the UK in 2018. It has been estimated that one third of female suicides may be related to IPA,[43] which would equate to nine or ten suicides per week. This number is thought to have increased in COVID-19, with 38 suspected suicides of victims of domestic abuse reported from 1st April 2020 to 31st March 2021.[44] Suicidality is more prevalent amongst women who are domestically abused than those women who are not abused.[45]

5.1.2 Analysis undertaken by Kent and Medway Suicide Prevention Team[46] of the 93 nationally published DHRs, found that 26% contained suicide of either the victim or the perpetrator.

5.1.3 The most recent report from the National Confidential Inquiry into Suicide and Safety in Mental Health,[47] found that between 2015 and 2019, there were 532 patients who were known to have experienced domestic violence: 9% of all patients during this time, 104 deaths per year. The average number in 2016 – 17 was 101 per year, but in 2018 – 19, this had increased to 149 per year. The majority (73%) were female: an average of 76 per year.

5.1.4 Women with a history of domestic violence were more likely to be younger than other women, and be single or divorced, living alone, and unemployed. The majority (81%) had a history of self-harm, and previous alcohol (61%) and/or drug (47%) misuse was common. Nearly a third (29%) had been diagnosed with personality disorder.

5.1.5 More women with a history of domestic violence had experienced adverse life events in the previous 3 months (115, 50% v. 351, 32%): the most common relating to family issues (21% v. 6%), serious financial problems (22% v. 11%), and loss of job, benefits, or housing (19% v. 12%).

5.2 The time prior to Jane's death

5.2.1 In the time prior to her death, Jane had told her mother that she wanted to have a better relationship with her.

5.2.2 Jane had been looking forward to her brother's wedding and had purchased a new dress for the occasion.

5.2.3 She had a new TV and was doing up her flat, which her mother thought was a good sign. A friend had told Jane's brother that she had 'blitzed' her flat in the week before her death.

[43] Walby, 2004, Stark and Flitcraft, 1996 cited in ibid.
[44] Bates et al., 2021, cited in ibid.
[45] Reviere, S., Farber, E., Tworney, H., Okun, A., Jackson, E. & Zanville, H. (2017) 'Intimate Partner Violence and Suicidality in Low-Income African American Women: A Multimethod Assessment of Coping Factors.' Violence Against Women 13: 1113-1129; Pico-Alfonso, M., Garcia-Linares, I., Celda-Navarro, N., Blasco-Ros, C, Echeburua, E. & Martinez, M. (2006) 'The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety and Suicide.' Journal of Women's Health 15(5): 599-611. Cited in Domestic abuse and suicide, Refuge and Warwick Law School, 2018.
[46] Highlighting the relationship between domestic abuse and suicide, Transforming health and social care in Kent and Medway, 2020
[47] The National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report 2022: UK patient and general population data 2009-2019, and real-time surveillance data, University of Manchester, 2022

5.2.4 Jane's father said that in the last 2 – 3 years, her state of mind and physical health had gone downhill. He wondered if Jane thought that nothing was going to change. Her mother agreed with this statement and added that it was during this time that Jane was in a relationship with Richard.

5.2.5 Jane's friend said that she thought that Jane believed that, because she had been ill for so long, she would always be ill. She could not shake off the paranoia and so she just gave up.

5.2.6 Jane's mental health assessment in 2016, identified that she could present with fixed beliefs regarding being evil and that she would not get better. She found it hard to believe that she could exist outside of the system.

5.2.7 Her friend said that when she was in the flat in the evenings, Jane felt lonely and found it hard to be alone, as she had been in hospital for so long. She said that Jane did not want to be alone and so would allow anyone to stay at her flat. She said that she did not think that she deserved a good man, only 'lowlifes'.

5.2.8 Jane's friend said that towards the end of her life, Jane spoke more and more about the voices that she was hearing. She said that they told her that she was a waste of space and useless. She said that the voices were telling her to end her life. The last time Jane's friend saw her, her flat was messy, and she did not want to do anything. She had no energy and could not do her chores.

5.3 From research into suicide, what can we learn about Jane's decisions?

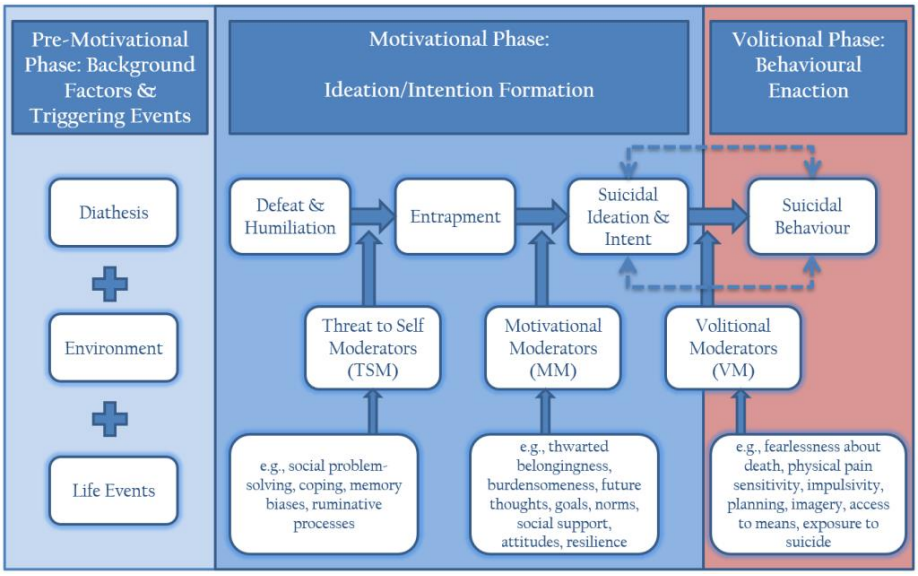
5.3.1 **THE INTEGRATED MOTIVATIONAL-VOLITIONAL (IMV) MODEL[48]**

5.3.2 Suicide is complex, and the journey of suicidal ideation to suicidal behaviours is not static but fluid and can be seen as being cyclical in nature. The Integrated Motivational-Volitional (IMV) model aims to synthesise, distil, and extend our knowledge and understanding of why people die by suicide, with a particular focus on the psychology of the suicidal mind. It proposes that defeat and entrapment drive the emergence of suicidal ideation and that a group of factors (volitional moderators) govern the transition from suicidal ideation to suicidal behaviour.

5.3.3 This model includes:

- The pre-motivational phase – background factors and triggering events
- The motivational phase – ideation and intention formation and the factors that govern the transition from suicidal ideation to suicide attempts
- The volitional phase – suicide attempts or death by suicide.

[48] The integrated motivational-volitional model of suicidal behaviour, O'Connor RC and Kirtley OJ, Royal Society Publishing, 2018



5.3.4 The IMV model of suicidal behaviour is based on seven key premises:

(1) Vulnerability factors combined with stressful life events (including early life adversity) provide the backdrop for the development of suicidal ideation
(2) The presence of pre-motivational vulnerability factors (e.g., socially prescribed perfectionism) increases the sensitivity to signals of defeat
(3) Defeat/humiliation and entrapment are the key drivers for the emergence of suicidal ideation
(4) Entrapment is the bridge between defeat and suicidal ideation
(5) Volitional-phase factors govern the transition from ideation/intent to suicidal behaviour
(6) Individuals with a suicide attempt or self-harm history will exhibit higher levels of motivational and volitional-phase variables than those without a history
(7) Distress is higher in those who engage in repeated suicidal behaviour and over time, and intention is translated into behaviour with increased rapidity.

5.3.5 This model can be an effective tool to help map a story of suicide and highlight specific points or factors of which the review should take note. The Report Author has used this model to explore what is known about Jane.

5.3.6 **Pre-motivational phase – Background factors and triggering events**

5.3.7 The first phase sets the context for suicidal ideation, and Jane experienced many vulnerability factors and stressors, some of which have been discussed in previous sections, as well as environmental influences that should be noted when considering the suicide risk:

- Early life adversity
- Long-term physical health concerns
- Social isolation
- Unemployment
- Relationship problems
- Domestic abuse
- Previous suicide attempts.

5.3.8 **Motivational phase – Emergence of suicidal ideation**

5.3.9 The centre column of the table highlights the key drivers: defeat, humiliation, and unbearable entrapment for the emergence of suicidal ideation.

5.3.10 Connor and Kirtley[49] say that entrapment can be internal or external in nature:

- Internal – concerned with being trapped by pain triggered by internal thoughts and feelings
- External – relates to the motivation to escape from events or experiences in the outside world.

5.3.11 Feelings of entrapment are likely to give rise to agitation. Whilst this phase is consistent with Williams' cry of pain hypothesis that is discussed later in the report, feelings of entrapment are distinct from hopelessness, which is a pervasive sense of pessimism for the future.

5.3.12 According to the IMV model, the presence or absence of threat to self-moderators, renders it more or less likely that defeat leads to entrapment. If we consider the potential threat to self-moderators, we can observe that Jane was struggling to cope with her chronic and painful physical conditions, as well as coercive and controlling behaviour/domestic abuse.

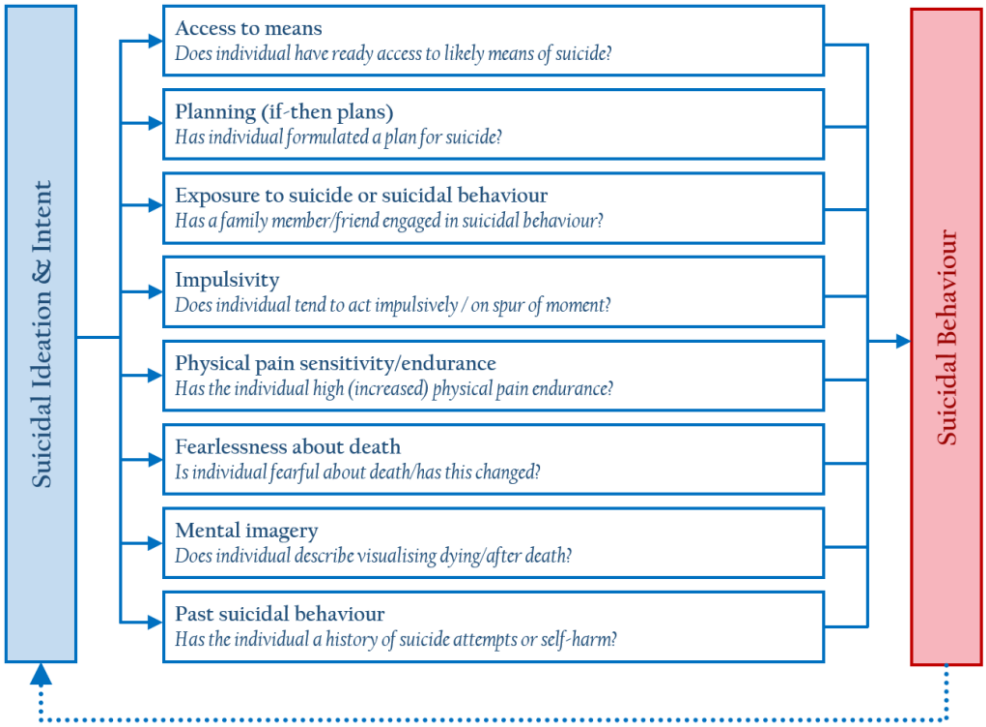
5.3.13 The final part of the motivational phase is the transition from entrapment to suicidal ideation. It is suggested that the presence of motivational moderators will increase or decrease the likelihood of entrapment being translated into suicidal ideation. Whilst the motivational moderators such as belongingness, connectedness, or attainable positive future thinking may provide a person with reasons for living; conversely, other motivational moderations such as feeling a burden and depleted resilience can lead to an increase in the likelihood of entrapment.

5.3.14 From what friends and family have told us, we know that Jane felt that nothing would ever change, both with her physical and mental health. She believed that because she had been ill for so long, she would always be ill. Her friend said that she just gave up. Jane's mother believes that the voices that she heard would have reinforced the feelings of hopelessness.

5.3.15 **Volitional phase: Behavioural enaction**

5.3.16 This third phase considers the transition from ideation to intent. It has been identified that there are eight volitional factors from suicidal ideation to suicidal behaviour.

[49] The integrated motivational-volitional model of suicidal behaviour, O'Connor RC and Kirtley OJ, Royal Society Publishing, 2018



5.3.17 If we apply what we know about Jane, we can build a picture:

Access to means

- Jane clearly had access to medication, both prescribed and 'over the counter'
- When in mental health crisis, Jane had been found in possession of a knife, which she had threatened to use to protect herself from Richard
- Jane had threatened to drink bleach to end her life
- In the past, Jane had tried to hang herself at home with a ligature.

Planning

- Jane had planned to take bleach when she rang NHS 111
- In March 2021, Jane sent a text message to a police officer to say that she had a suicide plan. She confirmed on the phone that she had a plan in her head but no immediate intentions
- Before taking her life, Jane sent an email to the police, telling them what she had taken, that she had two cats, and that the key was under the doormat.

Exposure to suicide or suicidal behaviour

- Jane's mother has confirmed that she did know people who had taken their life or had attempted to do so, including her uncle.

Impulsivity

- One of the features of emotionally unstable personality disorder is impulsivity
- In June 2020, Jane contacted mental health services and said that she felt that she needed to be hospitalised, as she was worried about 'outbursts and acting impulsively'.

Physical pain sensitivity/endurance

- Jane experienced fibromyalgia, which meant that she experienced pain and chronic fatigue
- In August 2020, Jane reported that her pain was worse and was affecting her mobility and incontinence. This impacted her ability to undertake personal care.

Fearless about death

- When Jane was asked in March 2021 if she had thoughts to end her life, she said: 'it's not a life, it's an existence'.
- When spoken to by the First Response team on 11th March, low mood with suicidal ideation was evident.

Past suicidal behaviour

- Jane had a history of suicide attempts, including overdoses, walking onto a dual carriageway and being hit by a car, setting herself on fire, and cutting an artery in her leg and tendons in her wrists. She had tried to hang herself at home with a ligature
- Devon and Cornwall Police had a marker on Jane's name for risk of suicide. This appears to originate from an incident in March 2006, when she attempted to jump from the top of a multi-storey car park.

5.3.18 Whilst we can see that Jane has evidence of at least seven of the eight volitional factors, this should not be seen as a checklist for risk. Each factor will tell a story and provide an opportunity to explore her safety. If the risks are addressed, then the risk is lowered.

5.3.19 Given that Jane had a history of suicidal ideation and suicide attempts, the one important question is that when she expressed such thoughts, whether these were explored with her on each occasion.

Suicide risk is not linear, it is constant and repeated. It would be best practice to ensure that each time a patient or client speaks about suicide, that this is discussed with them to assess and mitigate the risk at that time. Information should be shared with any relevant service. The risk should be reassessed during the next contact.

Recommendation 3

It is recommended that Devon Partnership Trust and the GP practice reassure the Community Safety Partnership that they have mechanisms in place to ensure that this approach is embedded into services.

5.3.20 It is important to note that Jane used overdose to end her life. People who use overdose have been described as ambivalent about waking up; they just want to take the pain away at that point.

5.3.21 People who are suicidal have been described as in a tug of war – between wanting to die and wanting to live. Towards the end of her life, Jane appeared to be looking to the future – with buying new things for her flat and telling her mother that she wanted to improve their relationship.

5.4 Cry of pain

5.4.1 Refuge,[50] in their research, explains that Weaver, et al. and Williams developed understanding about suicidality through what they called a 'cry of pain' hypothesis. According to this theory, suicidal acts (completed or not) are understood as a cry of pain, rather than a cry for help, with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible. It is suggested further that this constellation of feelings and beliefs can lead anyone, irrespective of psychiatric diagnosis, to consider, and even enact, suicide. A key finding, observed across several studies, is that previous suicidal behaviour, regardless of cause, is one of the most robust predictors of future suicide, with some research indicating that completed attempt often follows an uncompleted attempt within an average of one year. Therefore, to dismiss suicidality and attempts as 'merely a cry for help' risks ignoring those who are in the greatest psychological pain and more likely to take their own lives in the future.

5.4.2 In 2016, a full mental health assessment noted that Jane had ongoing chronic depression, suicidal ideation, and strong beliefs that she could not recover. Her suicidal ideation was said to be part of the EUPD and was necessary for her to hold on to as an escape from unbearable psychological pain.

5.5 Hope

5.5.1 Research undertaken by Refuge,[51] states that: 'those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide'.

5.5.2 The power of hope has been studied by The Hope Research Centre at the University of Oklahoma. Domestic abuse victims can often only see the present – day-to-day survival – but are unable to see a future outside of the current situation. It has been argued that hopelessness can focus individuals on the short term, with little vision for the long term (Hellman 2021).[52]

5.5.3 Hope is defined as the ability to see beyond the immediate situation, and plan or visualise a future. Saleebey (2000) contends that hope is a cognitive set, essential to resilience and recovery. He said: 'Hope is about imagining the possible, the "untested feasible" as Frieire would have it. But more specifically, it is about thinking of oneself as an *agent*, able to effect some change in one's life, having *goals* that not only have the promise but also *pathways* to their accomplishment – pathways that may be short or long, full of ruts or smooth, well-lit or darkened'.[53]

5.5.4 Friere, a pioneer in the study of individuals facing oppression, points to the importance of hope to resilience. He says: 'There is no change without the dream, as there is no dream

[50] Domestic abuse and suicide, Refuge and Warwick Law School, 2018.
[51] ibid.
[52] Hellman C, The Science of Rape, St Mary's Centre SARC Annual Conference Virtual 16-17 March 2021, cited in cited in Monckton Smith et al., University of Gloucestershire, Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing and intimate partner homicide, 2021
[53] The Relationship between Hope and Life Satisfaction among Survivors of Intimate Partner Violence: the Enhancing Effect of Self Efficacy, Munoz, Hellman and Brunk, Applied Research Quality of Life, 2017.

without hope'.[54] Research undertaken by Aitken and Munro (2018),[55] identified that 96% of victims of Interpersonal Abuse (IPA) who were identified as suicidal, suffered from feelings of hopelessness and despair, and that these feelings are a key determinant for suicidality.

5.5.5 Jane appeared to feel powerless and to have no control over her life. She did not feel able to go out, to cook for herself, and at times, was unable to undertake personal care. She had tried to leave her abusive relationship but, towards the end of her life, told professionals that Richard was there as a friend. We do not know if this was true, or if they had resumed their relationship, but it is very likely that he was controlling the relationship and what Jane said to others about it.

5.6 Local Suicide Prevention Strategy

5.6.1 The national suicide prevention strategy[56] was first published in 2012. Its key aims were to reduce the suicide rate in the general population in England and to better support those bereaved or affected by suicide.

5.6.2 To support this strategy, the NHS asked all Integrated Care Boards to deliver local multi-agency suicide prevention plans.

5.6.3 Suicide and self-harm are often precipitated by recent adverse events across the life course. These include relationship breakdowns, conflicts, legal problems, financial concerns, interpersonal losses, and traumatic events.

5.6.4 Research has shown that, in terms of suicide prevention, it is important to note that the experience of sexual or domestic violence in adulthood is associated with the onset and persistence of depression, anxiety and eating disorders, substance misuse, psychotic disorders, and suicide attempts.[57]

5.6.5 Torbay has a Suicide and Self-harm Prevention Plan: published in August 2022.[58] The priorities of this plan are:

- Reduce social isolation and loneliness
- Promote a 'culture of curiosity', both publicly and professionally
- Address system gaps for people with severe mental illness (in partnership with the Community Mental Health Framework redesign)
- Tackle high frequency locations
- Support research and data collection
- Tackle basic needs first
- Tailor approaches to improving mental health in children and young people.

[54] The Psychology of Resilience: A Model of the Relationship of Locus of Control to Hope Among Survivors of Intimate Partner Violence, Munoz RT, Brady S and Brown V, Traumatology, 2016.
[55] Aitken R and Munro V, Domestic Abuse and Suicide: Exploring the Links with Refuge's Client Base and Work Force, Refuge, 2018 cited in Monckton Smith et al., University of Gloucestershire, Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing and intimate partner homicide, 2021
[56] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[57] Hawton K, Van Heeringen K. The International Handbook of Suicide and Attempted Suicide. The International Handbook of Suicide and Attempted Suicide. 2008 cited in ibid.
[58] https://www.torbay.gov.uk/media/16416/torbay_suicide_prevention_plan_24_27_final-full.pdf

Recommendation 4

It is recommended that the work of the Torbay Mental Health and Suicide Prevention Alliance pays attention to the research and needs of those who are experiencing, or have experienced, domestic or sexual abuse.

5.6.6 The following priorities are being addressed across Devon:

- Devon-wide real-time surveillance.

Recommendation 5

It is recommended that the real-time surveillance pays attention to the link between suicide and domestic/sexual abuse.

- Devon-wide suicide prevention training (public, professionals, and primary care)

Recommendation 6

It is recommended that the training includes reference to the links between domestic/sexual abuse and suicide.

- Devon-wide media and communication programme
- Devon and Torbay – Embedding NCISH '10 ways to improve patient safety in acute and community mental health provision'
- Devon-wide online mental health and well-being support (adults).

Section Six – Lessons Identified

6.1 When a DVPN is issued, the time should be used to provide the victim with details of support services that can help them.

6.2 In December 2020, Devon and Cornwall Police did not take the opportunity to share with partner agencies, their concerns about Jane's vulnerability.

6.3 The DASH risk assessment, whilst including a question about strangulation, only allocates one tick – as with every answer. The review believes that this does not reflect the high risk that non-fatal strangulation poses.

6.4 Suicide risk is not linear: it is constant and repeated. It would be best practice to ensure that whenever engaging in a conversation about suicide with a patient/client, that this is discussed with them to assess and mitigate the presented risk. The risk should be reassessed during the next contact and/or information should be shared with a relevant service for this to be continued.

6.5 Jane's family believe that in-person contact would be most effective when assessing suicide risk.

Section Seven – Recommendations

7.1 **Devon and Cornwall Police**

7.1.1 That the Force uses this incident (anonymised) as an example of the type of individuals and circumstances that should attract a PPN (Public Protection Notice). This should then be shared through local learning bulletins.

7.2 **Devon Partnership Trust and Jane's GP practice**

7.2.1 That Devon Partnership Trust and the GP practice reassure the Community Safety Partnership that they have mechanisms in place to ensure that this approach[59] is embedded into services.

7.3 **Home Office**

7.3.1 That the Home Office instigates a review into DASH risk assessments to ensure that where strangulation is a factor, the risk is rated as high – regardless of the other answers given.

7.4 **Torbay Mental Health and Suicide Prevention Alliance**

7.4.1 That the work of the Torbay Mental Health and Suicide Prevention Alliance pays attention to the research and needs of those who are experiencing, or have experienced, domestic or sexual abuse.

7.4.2 That the real-time surveillance pays attention to the link between suicide and domestic/sexual abuse.

7.4.3 That the suicide prevention training includes reference to the links between domestic/sexual abuse and suicide.

[59] Suicide risk is not linear: it is constant and repeated. It would be best practice to ensure that whenever engaging in a conversation about suicide with a patient/client, that this is discussed with them to assess and mitigate the presented risk. The risk should be reassessed during the next contact and/or information should be shared with a relevant service for this to be continued.

Section Eight – Conclusions

8.1 This is a truly tragic case in which a young woman's life has been taken as a result of an overdose of drugs.

8.2 Whether that overdose was intentional, or otherwise, is a matter for HM Coroner alone to determine.

8.3 What is clear is that a combination of domestic abuse, the unintended consequences of COVID-19 regulations upon Jane's state of mind, and Jane's long-standing mental ill-health and thus her vulnerabilities, all probably contributed to her death – intentional or otherwise.

8.4 A delay in the police responding to an email sent by Jane – in which she detailed the tablets she had taken and that she had two cats – is rightly being reviewed by the Independent Office for Police Conduct (IOPC). This review should not comment upon that investigation. It will make its own recommendations. However, this review does not find that Devon and Cornwall Police dealt with Jane in anything other than a sensitive and considerate way – in all their previous dealings with her.

8.5 Learning has been identified as a result of our scrutiny of this case, and we believe the six recommendations that we make, will contribute to making life safer for others in the future.

Appendix One – Terms of Reference

SAFER TORBAY

Terms of Reference for the Domestic Homicide Review into the death of Jane

1 **Introduction**

1.1 This Domestic Homicide Review (DHR) is commissioned by Safer Torbay in response to the death of Jane, who died in March 2021.

1.2 The review is commissioned in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the Partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Independent Report Author, respectively, for the purpose of this review. Neither Christine Graham nor Gary Goose is employed by, nor is otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2 **Purpose of the Review**

The purpose of the review is to:

2.1 Establish the facts that led to the **discovery of Jane's death,** and whether there are any lessons to be learned from the case about the way that professionals and agencies worked together to safeguard **her.**

2.2 Identify what those lessons are, how they will be acted upon, and what is expected to change as a result.

2.3 Apply these lessons to service responses, including changes to inform national and local policies and procedures, as appropriate.

2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

2.5 Contribute to the understanding of the nature of domestic abuse.

3 **The Review Process**

3.1 The review will be cognisant of the Statutory Guidance for Domestic Homicide Reviews, in accordance with the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with, the criminal investigation into **Jane's** death and the process of inquest held by HM Coroner.

3.3 This review will liaise with other parallel processes that are ongoing or imminent, in relation to the incident, in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable: that is a matter for the criminal and coroners' courts.

4 Scope of the Review

The review will:

4.1 Draw up a chronology of the involvement of agencies involved in the life of Jane to determine where further information is necessary. Where this is the case, Individual Management Reviews (IMRs) will be required by relevant agencies, defined in Section 9 of the Act.

4.2 Produce IMRs for the time period from 1st January 2021 to the date of Jane's death.

4.3 Invite responses from other relevant agencies, groups, or individuals identified through the process of the review.

4.4 Consider the impact of COVID-19 lockdown on Jane's mental health.

4.5 Consider the impact of domestic abuse on Jane's mental health, whether any potential impact was recognised, and whether she was supported.

4.6 Consider the impact of Jane's mental health on her ability to seek help in relation to the domestic abuse that she had experienced.

5 Family Involvement

5.1 The review shall seek to involve **Jane's** family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support, and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews; thereby, avoiding duplication of effort and minimising their levels of stress and anxiety.

6 The Overview Report

6.1 The review will produce a report that summarises the chronology of events, including the actions of involved agencies, analyses and comments on the actions taken. The report will make any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

6.2 Aim to produce a report within the timescales suggested in the statutory guidance, subject to:

- guidance from the police as to any sub-judice issues
- sensitivity in relation to concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

7 Legal Advice and Costs

7.1 Each statutory agency will be expected to inform their legal departments that the review is taking place. The costs of legal advice and involvement of their legal teams are at their discretion.

7.2 Should the Independent Chair, Chair of the CSP, or the Review Panel require legal advice, then **Torbay CSP** will be the first point of contact.

8 Media and Communications

8.1 The management of all media and communication matters will be through the Review Panel, escalating to the CSP Chair as necessary.

Gary Goose and Christine Graham
Independent Chair and Overview Report Author

Appendix Two – Ongoing Professional Development of Chair and Report Author

1.1 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews - Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
- Giving children a voice in DHRs – AAFDA (November 2021)
- Cross Cultural Training Webinar – Incels and Online Hate – HOPE Training (November 2021)
- Male victims of domestic abuse, Buckinghamshire DHR Learning Event (January 2022)
- Older victims of domestic abuse, Dr Hannah Bows, DHR Network (February 2022)
- Enhancing the cancer workforce response to domestic abuse – Standing Together and Macmillan (April 2022)
- Understanding Trauma – Delivered by Nikki Dhillon Keane (September 2022).

1.2 Christine has completed the Homicide Timeline Online Training (Five Modules), led by Professor Jane Monckton-Smith of University of Gloucester.

1.3 Gary and Christine have:

- Attended training on the statutory guidance update (May 2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol, June 2018)
- Attended AAFDA Learning Event (Bradford, September 2018)
- Attended AAFDA Annual Conference (March 2017, 2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
- Attended AAFDA DHR Chair Refresher Training (August 2021)
- Commissioned bespoke training on DHRs and Suicide, Harmless (March 2022)
- Attended Strangulation and Suffocation: Introduction to the new offence for England and Wales, Training Institute of Strangulation Prevention (July 2022).